## HARMONY SURGERY CENTER, LLC

Patient Admission Assessment Form

Driver Name:       Driver Phone Number:         "Prior to your discharge, du you grant our staff permission to go over procedural information, medications and discharge instructions with your ride?       Yes       No         Allergies (medications, latex, products):       None       Mone Care       Community Resources Equipment         Or you responsible party need information on the following (circle needs)?       Medications       Treatment/Procedures         Current Uliness       Dist/Muttino       Hands-on       Other:         Barriers to learning or care (Please Circle)       Listening       Deading       Hands-on       Other:         Pain Evaluation:: Current Pain?       Differ       Location:       Description (circle): Dull Sharp Burning Aching       Currently have a contagious or infectious condition?       Description (circle): Dull Sharp Burning Aching       Currently have a contagious or infectious condition?       Description (circle): Dull Sharp Burning Aching       Currently have a contagious or infectious condition?       Description (circle): Dull Sharp Burning Aching       Currently have a contagious or infectious condition?       Description (circle): Dull Sharp Burning Aching       Currently have a contagious or infectious condition?       Description (circle): Dull Sharp Burning Aching       Currently have a contagious or infectious condition?       Description (circle): Dull Sharp Burning Aching       Currently have a contagious or infectious condition?       Description (circle): Dull Sharp Burning Aching       De	Who is taking you home today? (note – you are advised to have a responsible adult with you for 24 hours after procedure):							
**Prior to your discharge, do you grant our staff permission to go over procedural information, medications and discharge instructions with your ride?       I Yes       No         Allergies (medications, latex, products):       None       None       None         Do you or your responsible party need information on the following (circle needs)?       Medications       Treatment/Procedures         Current liness       Follow-up care       Distance       Equipment         Perferent Laming or care (Please Circle)       None       Commonity Resources       Equipment         Partication:       Current pain treatment:       Please list any beionging you have with you:       None       Current pain treatment:         Please list any beionging you have with you:       Note:       Note:       None       Current pain treatment:         Please list any beionging you have with you:       Noe       Noe:       Noe:       Current pain treatment:         Please list any beionging you have with you:       Noe:       Noe:       Current pain treatment:       Please list any common pain with you have any you:         Noe:       Sizure/stroke or other neurological problem?       Noe:       Current pain treatment:       Please list any common pain with your have?       Current pain treatment:       Please list any common pain with you have?       Current you make degression:       Current you hany degresing you have with you: <t< td=""><td colspan="8">Driver Name</td></t<>	Driver Name							
with your ride?       Yes       No         Allergies (medications, latex, products):       None         Do you or your responsible party need information on the following (circle needs)?       Medications       Treatment/Procedures         Current lliness       Follow-up care       DistMutrition       Hygiene/Grooming/Oral Care       Home Care       Community Resources       Equipment         Preferred Learning Method (Please Circle)       Listening       Demonstration       Reading       Hands-on       Other:         Barriers to learning or care (Please Circle)       None       Cognitive       Hearing       Reading/Writing       Language       Culture       Vision         Pain Evaluation:       Current New Commond       Current New a contagious or infectious condition?       No         Sociarels/toke or other neurological problem?       Ves       No       Current New a contagious or infectious condition?       No         Pacemaker or defbrillato?       Diabetes and/or high biodo sugar?       Diabetes and/or high biodo sugar?       Diabetes and/or high biodo sugar?       Suffer from anizely, depression, panic tasks or       PTSD?         Pacemaker or defbrillato?       Suffer from mode (are, reaching with weit weit Need)       Diabetes and/or high biodo sugar?       Diabe								
Allergies (medications, latex, products): □ None         Do you ry cresponsible party need information on the following (circle needs)? Medications Treatment/Procedures Current Illess Follow-up care Dist/Nutrition Hygiene/Grooming/Oral Care Home Care Community Resources Equipment Prefered Learning Method (Please Circle) Listening Demonstration Reading Hands-on Other:         Barriers to learning or care (Please Circle) None Cognitive Hearing Reading/Writing Language Culture Vision Emotional Physical Financial Religion Other:       Location:         Pain Evaluation: Current Pain? □ Yes □ No If yes: Pain level (1-10) Location:       Location:         Description (circle): Dull Sharp Burning Aching       Currently have atomatics:       Yes No         Readin History:       Yes No       No If yes: Pain level (1-10) Location:       Description (circle): Dull Sharp Burning Aching       Currently have a contagious or infectious condition?         Pasce list any belongings you have with you:       Yes No       No       Evaluation:       Yes No         Secure/stroke or other neurological problem?       Yes No       No       Evaluation:       Yes No         Secure/stroke or other neurological problem?       Illness. infection or fever in the past 2 week?       Diabetes and/or nigh blood sugar?       Illness infection or fever in the past 2 week?       Diabetes and/or nigh blood sugar?       Illness infection or fever in the past 3 days?       Stiff from anxiely, deression, pain attacks or PISO?       Stiff from anxiely, deression, pain attacks or PISO?       St								
Currient Illness       Follow-up care       Diet/Nutrition       Hygiene/Grooming/Crait Care       Home Care       Community Resources       Equipment         Preferred Learning or care (Please Circle)       None       Cognitive       Heading/Writing       Language       Culture       Vision         Emotional       Physical       Financial       Religion       Other:       Description       Current pain treatment:         Pain Evaluation:       Current pain treatment:       Please saint of the pain treatment:       Ves       No         Not:       HSC is not responsible for belongings.       Please give all valuables to your ride home.       Ves       No         Sazureistroke or other neurological problem?       Describe:       Currently have a contagious or infectious condition?       Describe:         Problems with your heart?       Diabetes andor high blood sugar?       Describe:       Diabetes andor high blood sugar?       Describe:         Problems with your heart?       Diabetes andor high blood sugar?       Describe:								
Preferred Learning Method (Please Circle)       None Cognitive       Hearing       Reading       Hands-on       Other:         Barriers to learning or care (Please Circle)       None Cognitive       Hearing       Reading/Writing       Language       Culture       Vision         Pain Evaluation:       Current Pain?       Ves       No       Hyes: Pain level (1-10)       Location:         Description (circle):       Dull Sharp Burning Aching       Current pain treatment:       Please list any belongings you have with you:         Note:       Note:       No       Heath History Continued:       Yes       No         Beschiption (circle):       Dull Sharp Burning Aching       Current pain treatment:       Please list any belongings you have with you:         Note:       No       Heath History Continued:       Yes       No         Sugardia:       Current pain treatment:       Please list any belongings.       Yes       No         Beschiption:       Lines:       No       Heath History Continued:       Yes       No         Beschiption:       Lines:       Sugfor from anxiety. depression, paric attacks or       Plasting: from anxiety. depression, paric attacks or       Plasting: from anxiety. depression, paric attacks or       Problems with your tesh?       Line from anxiety. depression, paric attacks or         Presense:								
Barriers to learning or care (Please Circle)       None Čognitive       Hearing Reading/Writing Language Culture Vision         Emotional Physical Financial Religion Other:       Describe:       Current pain treatment:         Description (circle): Dull Sharp Burning Aching       Current pain treatment:       Current pain treatment:         Plaese list any belongings you have with you:       Not Hys: Iso not responsible for belongings. Please give all valuables to your ride home.       Not Hys: Iso not responsible for belongings. Please give all valuables to your ride home.         Heath History:       Yes       No         Seizure/stroke or other neurological problem?       Least histop:       Yes       No         Seizure/stroke or other neurological problem?       Least histop:       Diabetes and/or high blood sugar?       Currently have a contagious or infectious condition?       Diabetes and/or high blood sugar?       Currently have a contagious or infectious condition?       Diabetes and/or high blood sugar?       Currently faver a contagious or infectious condition?       Diabetes and/or high blood sugar?       Currently faver a contagious or infectious condition?       Diabetes and/or high blood sugar?       Currently faver a contagious or infectious condition?       Diabetes and/or high blood sugar?       Currently faver a contagious or infectious condition?       Diabetes and/or high blood sugar?       Currently faver and/as days?       Diabetes and/or high blood sugar?       Currently faverast a days?       Suffer from anxiety, depression, panic								
Emotional       Physical       Financial       Religion       Other:         Pain Evaluation:       Current Pain?       Ves       No       If yes: Pain level (1:10)       Location:         Description (circle):       Dull       Sharp       Burning       Aching       Current pain treatment:         Please list any belongings you have with you:       Note: HSC is not responsible for belongings. Please give all valuables to your ride home.         Heath History:       Yes       No         Secure/stroke or other neurological problem?       Currently have a contagious or infectious condition?       Yes         Describe:       Describe:       Diabetes and/or high blod sugar?       Describe:         Describe:       Diabetes and/or high blod sugar?       Diabetes and/or high blod sugar?       Describe:         Shortness of breath with exertion or exercise?       Suffer from anxiety, depression, panic attacks or       PTSD?         Stortness of problems set for cardiac bypass?       Used recreational drug(s) within the last 3 days?       Diabetes and/or high blod sugar?       Describe:         Blood tinner medication?       Describe:       Describe:       Describe:       Describe:       Describe:       Describe:       Diabetes and/or high blod sugar?       Describe:       Describe:       Diabetes and/or high blod sugar?       Describe:       Diabetes and/or high b		-						
Pain Evaluation:       Current Pain?       Yes       No       If yes: Pain level (1-10)       Location:         Description (drcle):       Dull       Sharp       Burning       Aching       Current pain treatment:         Please list any belongings you have with you:       Yes       No       Superstrict the history:       Yes       No         Secure/stoke or other neurological problem?       Yes       No       Yes       No         Describe:       Describe:       Describe:       Illness, infection or fever in the past 2 weeks?       Describe:         Describe:       Describe:       Disorders and the sertion or exercise?       Suffer from anxiety, depression, panic attacks or       Pressore         Stortness of breath with exertion or exercise?       Suffer from anxiety, depression, panic attacks or       Pristo?         Cardiac stent/blood vessel stent or cardiac bypass?       Used recreational drug(s) within the last 3 days?       Disorders         Disord inner medication?       Dialy       Weekly       Describe:       Describe:         Disorder?       Describe:       Desocribe: <td></td> <td></td> <td>Initive</td> <td>He</td> <td>earing Reading/vvriting Language Culture Vis</td> <td>sion</td> <td></td>			Initive	He	earing Reading/vvriting Language Culture Vis	sion		
Description (circle): Dull Sharp Burning Aching       Current pain treatment:         Please list any belongings you have with you:       No         Note: HSC is not responsible for belongings. Please give all valuables to your ride home.       Yes No         Heath History:       Yes No         Seizuréstricke or other neurological problem?       Describe:         Describe:       Describe:         Problems with your heart?       Describe:         Describe:       Diabetes and/or high blood sugar?         Chest pressure, chest pain?       Taken stroids (i.e. Prednisone) in the last year?         Stortness of breath with exertion or exercise?       Stiffer from anxiety, depression, panic attacks or         Pacemaker or defibrillator?       Used recreational drug(s) within the last 3 days?         Used recreational drug(s) within the last 3 days?       Diatuses and/or high blood sugar?         Blood tinner medication? Clotting problems?       Dentures or problems throug(s) within the last 3 days?         Blood disorder?       Describe:         Autoimmune disorder?       Describe:         Describe:       Diatest analy or walker, cane, etc.?         Autoimmune disorder?       Prequent hearts may possibility you cuteth?         Describe:       Diatest analy obducts under any circumstances?         Dayo uurently smoke?       Problems with anesthesia (self or bloo								
Note: HSC is not responsible for belongings. Please give all valuables to your ride home.       Yes       No         Heath History:       Yes       No         Bescribe:       Listory:       Yes       No         Describe:       Listory:       Listory:       Yes       No         Describe:       Listory:       Listory:       Listory:       Mo         Chest pressure:       Listory:       Listory: <thlistory:< th=""> <thlistory:< th="">       &lt;</thlistory:<></thlistory:<>				`				
Health History:       Yes       No         Seizure/stroke or other neurological problem?								
Seizure/Stoke or other neurological problem?       Currently have a contagious or infectious condition?         Describe:       Illness, infectious or infectious condition?         Problems with your heart?       Diabetes and/or high blood sugar?         Chest pressure, chest pain?       Taken steroids (i.e. Prednisone) in the last year?         Shortness of breath with exertion or exercise?       Suffer from anxiety, depression, panic attacks or PTSD?         Pacemaker or defibrillator?       Used recreational drug(s) within the last 3 days?         Cardia cstent/blood vessel stent or cardiac bypass?       Used recreational drug(s) within the last 3 days?         Blood thinner medication? Clotting problems?       Diahutes and/or applin-like meds (i.e., Motrin, Aleve, Ibeoritie:         Blood disorder?       Eye or vision problems with your teeth?         Eye or vision problems with your teeth?       Eye or vision problems?         Autoimmune disorder?       Eye or vision problems?         Describe:       Dispective         Lung problems or problems breathing?       Problems with anesthesia (self or blood-relative)?         Describe:       Dispective         Lung problems?       Problems with anesthesia?         Supplemental oxygen?       Is there any possibility you could be pregnant? IN/A         Gastrointestinal problems?       Dive or Matorey         Liver problems?       Oby ou have	Note: HSC is not responsible for belongings. Please g			ables				
Describe:       Describe:         Problems with your heart?       Describe:         Describe:       Diabetes and/or high blood sugar?         Chest pressure, chest pain?       Taken steroids (i.e. Prednisone) in the last year?         Shortness of breath with exertion or exercise?       Suffer from anxiety, depressione, panic attacks or         Pacemaker or defibrillator?       Pacemaker or defibrillator?         Cardiac stent/blood vessel stent or cardiac bypass?       Used recreational drug(s) within the last 3 days?         Blood thinner medication? Clotting problems?       Smoked or consumed marijuana in the past 3 days?         Blood disorder?       Describe:         Describe:       Describe:         Lung problems or problems breathing?       Problems with anesthesia (self or blood-relative)?         Describe:       Describe:         Lung problems?       Do you currently smoke?         Have you ever smoked? When did you quit?       Describe:         Supplemental oxygen?       Is there any possibility you could be pregnant? INVA         Step apmea? CPAP? Oxygen at night?       Date of your last menstrual period? INVA         Date of your last menstrual period? INVA       Det of your last menstrual period? INVA         Supplemental oxygen?       Is there any possibility you could be pregnant? INVA         Ithere any possibility you could be pregnant? INVA		es	No			res	No	
Problems with your heart?       Illness, infection or fever in the past 2 weeks?         Describe:       Diabetes and/or high blood sugar?         Chest pressure, chest pain?       Taken steroids (i.e., Prednisone) in the last year?         Suffer from anxiety, depression, panic attacks or PTSD?         Cardiac stent/blood vessel stent or cardiac bypass?       Used recreational drug(s) within the last 3 days?         Blood thinner medication? Clotting problems?       Smoked or consumed marijuana in the past 3 days?         Blood disorder?       Dentures or problems with your teeth?         Blood disorder?       Dentures or problems with your teeth?         Describe:       Autoimmune disorder?         Lung problems or problems or problems or problems?       Hearing problems?         Day ou currently smoke?       Problems with anesthesia (self or blood-relative)?         Describe:       Do you currently smoke?         Nave you ever smoked? When did you quit?       Describe:         Supplemental oxygen?       Is there any possibility you could be pregnant? IN/A         Gastorinetsinal problems?       Do you kave an Advance Directive: CPR Directive         Liver problems?       Date of your last mestrual period? IN/A         Gastorinetsinal problems?       Do you kave an Advance Directive: CPR Directive         Diarthea and/or addominal cramping? For how long?       Who is your Primary Care Doctor? <td>÷ .</td> <td></td> <td></td> <td></td> <td>, ,</td> <td></td> <td></td>	÷ .				, ,			
Describe:								
Chest pressure, chest pain?       Interface         Shortness of breath with exertion or exercise?       Interface         Shortness of breath with exertion or exercise?       Interface         Caraliac stent/blood vessel stent or cardiac bypass?       Interface         High blood pressure?       Smoked or consumed marijuana in the past 3 days?         Blood thinner medication? Clotting problems?       Drink alcohol?         Take aspirin or aspirin-like meds (i.e., Motrin, Aleve, Ibuprofen, etc.)?       Describe:         Blood disorder?       Describe:         Describe:       Describe:         Lung problems or problems breathing?       Problems with anesthesia (self or blood-relative)?         Describe:       Doiget to blood products under any circumstances?         Nave you ever smoked? When did you quit?       Describe:         Supplemental oxygen?       Elstere any possibility you could be pregnant? CIN/A         Steep apnea? CPAP? Oxygen at night?       Currently breastfeeding? CIN/A         Caractr treated with chemotherapy or radiation?       Weight:         Have you base nad/or addominal cramping? For how long?       Wo is your Primary Care Doctor?         Have you base nad/or addominal cramping? For how long?       Dey ou have an Advance Directive:         Deractreated with chemotherapy or radiation?       Weight:       Height:         Have you b	-							
Shortness of breath with exertion or exercise?       Suffer from anxiety, depression, panic attacks or PTSD?         Carcitac stent/blood vessel stent or cardiac bypass?       Suffer from anxiety, depression, panic attacks or PTSD?         High blood pressure?       Smoke dor consumed marijuana in the past 3 days?         Blood thinner medication? Clotting problems?       Smoke dor consumed marijuana in the past 3 days?         Drink alcohol?       Daily         Blood disorder?       Describe:         Autoimmune disorder?       Eye or vision problems?         Describe:       Describe:         Lung problems or problems breathing?       Preduent warthum?         Describe:       Object to blood products under any circumstances?         Nucl mark you ever smoked? When did you quit?       Supplemental oxygen?         Sleep apnea? CPAP? Oxygen at night?       Ever or you and formany?         Carret reated with chemotherapy or radiation?       Date of your last menstrual period?         Diarrea and/or abdominal cramping? For how long?       Diarter of patient or person completing form:         Weight:       Height:         Have you been hospitalized in the last 90 days?       Weight:								
Pacemaker or defibrillator?       PTSD?         Cardiac stent/blood vessel stent or cardiac bypass?       Used recreational drug(s) within the last 3 days?         High blood pressure?       Smoked or consumed marijuana in the past 3 days?         Blood thinner medication? Clotting problems?       Drink alcohol?         Take aspirin or aspirin-like meds (i.e., Motrin, Aleve, Ibuprofen, etc.)?       Drink alcohol?         Blood disorder?       Eye or vision problems?         Describe:       Use wheelchair, walker, cane, etc.?         Autoimmune disorder?       Eye or vision problems?         Describe:       Do you currently smoke?         Have you ever smoked? When did you quit?       Describe:         Do you currently smoke?       Describe:         Auto you ever smoked? When did you quit?       Describe:         Supplemental oxygen?       Is there any possibility you could be pregnant? DN/A         Steep apnea? CPAP? Oxygen at night?       Currently breastfeeding? DN/A         Kidney problems?       Date of your last menstrual period? DN/A         Diarrhea and/or abdominal cramping? For how long?       Date of your last menstrual period? DN/A         Diarrhea and/or abdominal cramping? For how long?       Who is your Primary Care Doctor?         Have you been hospitalized in the last 90 days?       Weight:       Height:         Have you been hospitalized		$\rightarrow$						
High blood pressure?   Blood thinner medication? Clotting problems?   Take aspirin or aspirin-like meds (i.e., Motrin, Aleve,   Ibuprofen, etc.)?   Blood disorder?   Describe:   Autoimmune disorder?   Describe:   Lung problems or problems breathing?   Describe:   Lung problems or problems breathing?   Describe:   Do you currently smoke?   Have you ever smoked? When did you quit?   Steep apnea? CPAP? Oxygen at night?   Kidney problems?   Diarrhea and/or abdominal cramping? For how long?   Thyroid, Parathyroid, or adrenal gland problems?   Cancer treated with chemotherapy or radiation?   Hear up ransplantImplants   Have you been hospitalized in the last 90 days?   Smoked or consumed marijuana in the past 3 days?								
Biod thiner medication? Clotting problems?   Take aspirin or aspirin-like meds (i.e., Motrin, Aleve, lbuprofen, etc.)?   Biod disorder?   Biod disorder?   Describe:   Autoimmune disorder?   Describe:   Lung problems or problems breathing?   Describe:   Lung problems or problems breathing?   Describe:   Do you currently smoke?   Have you ever smoked? When did you quit?   Sleep apnea? CPAP? Oxygen at night?   Kidney problems?   Diarrhea and/or abdominal cramping? For how long?   Diarrhea and/or abdominal cramping? For how long?   Diarrhea and/or abdominal cramping? For how long?   Thyroid, Parathyroid, or adrenal gland problems?   Cancer treated with chemotherapy or radiation?   Have you been hospitalized in the last 90 days?	Cardiac stent/blood vessel stent or cardiac bypass?				Used recreational drug(s) within the last 3 days?			
Take aspirin or aspirin-like meds (i.e., Motrin, Aleve, lbuprofen, etc.)?       Dentures or problems with your teeth?         Blood disorder?       Describe:         Autoimmune disorder?       Describe:         Autoimmune disorder?       Describe:         Lung problems or problems breathing?       Prequent heartburn?         Describe:       Object to blood products under any circumstances?         Problems with anesthesia (self or blood-relative)?       Describe:         Do you currently smoke?       Any concerns about anesthesia?         Have you ever smoked? When did you quit?       Describe:         Supplemental oxygen?       Is there any possibility you could be pregnant?         Liver problems?       Date of your last menstrual period?         Liver problems?       Other         Diarrhea and/or abdominal cramping? For how long?       Who is your Primary Care Doctor?         Thyroid, Parathyroid, or adrenal gland problems?       Describe:         Cancer treated with chemotherapy or radiation?       Weight:         Have you been hospitalized in the last 90 days?       Signature of patient or person completing form:					Smoked or consumed marijuana in the past 3 days?			
Ibuprofen, etc.)?       Eye or vision problems?         Blood disorder?       Eye or vision problems?         Describe:       Describe:         Lung problems or problems breathing?       Eye or vision problems?         Describe:       Do you currently smoke?         Have you ever smoked? When did you quit?       Describe:         Supplemental oxygen?       Stepe apnea? CPAP? Oxygen at night?         Kidney problems?       Date of your last menstrual period? IN/A         Gastrointestinal problems?       Do you carently on any of the following?         Diarrhea and/or abdominal cramping? For how long?       Who is your Primary Care Doctor?         Who is your Primary Care Doctor?       Weight:         Height:       Height:         Have you been hospitalized in the last 90 days?       Signature of patient or person completing form:	Blood thinner medication? Clotting problems?							
Blood disorder?								
Describe:       Image: problems in a strength					Eye or vision problems?			
Autoimmune disorder?       Image: Concentration of the following?         Describe:       Image: Concentration of the following?         Supplemental oxygen?       Image: Concentration of the following?         Sileep apnea?       CPAP? Oxygen at night?         Kidney problems?       Image: Concentration of the following?         Diarrhea and/or abdominal cramping? For how long?       Image: Concentration of the following?         Diarrhea and/or abdominal cramping? For how long?       Image: Concentration of the following?         Image: Concentrated with chemotherapy or radiation?       Image: Concentration of the following?         Image: Concentrated with chemotherapy or radiation?       Image: Concentration of the following?         Image: Concentrate of the last 90 days?       Signature of patient or person completing form:					Hearing problems?  Hearing Aids			
Describe:		-+						
Lung problems or problems breathing?       Image: Comparison of the following?         Describe:       Image: Comparison of the following?         Do you currently smoke?       Image: Comparison of the following?         Have you ever smoked? When did you quit?       Image: Comparison of the following?         Supplemental oxygen?       Image: Comparison of the following?         Signature of patient or person completing form:       Signature of patient or person completing form:								
Describe:		-+						
Do you currently smoke?       Any concerns about anesthesia?         Have you ever smoked? When did you quit?       Describe:         Supplemental oxygen?       Is there any possibility you could be pregnant? IN/A         Sleep apnea? CPAP? Oxygen at night?       Currently breastfeeding? IN/A         Kidney problems?       Date of your last menstrual period? IN/A         Gastrointestinal problems?       Do you have an Advance Directive: I CPR Directive         Liver problems?       Other         Diarrhea and/or abdominal cramping? For how long?       Other         Thyroid, Parathyroid, or adrenal gland problems?       Who is your Primary Care Doctor?         Who is your Primary Care Doctor?       Weight:         Have you been hospitalized in the last 90 days?       Signature of patient or person completing form:								
Have you ever smoked? When did you quit?       Any concerns about anestnesia?         Supplemental oxygen?       Is there any possibility you could be pregnant? IN/A         Sleep apnea? CPAP? Oxygen at night?       Is there any possibility you could be pregnant? IN/A         Kidney problems?       Is there any possibility you could be pregnant? IN/A         Gastrointestinal problems?       Date of your last menstrual period? IN/A         Liver problems?       Date of your last menstrual period? IN/A         Diarrhea and/or abdominal cramping? For how long?       Living Will I Power of Attorney I Other         Who is your Primary Care Doctor?       Who is your Primary Care Doctor?         Who is your perimary care Doctor?       Weight:         Have you bad surgery on any of the following?       Signature of patient or person completing form:         Have you been hospitalized in the last 90 days?       Signature of patient or person completing form:	Do you currently smoke?							
Supplemental oxygen?   Sleep apnea? CPAP? Oxygen at night?   Kidney problems?   Gastrointestinal problems?   Gastrointestinal problems?   Liver problems?   Diarrhea and/or abdominal cramping? For how long?   Thyroid, Parathyroid, or adrenal gland problems?   Cancer treated with chemotherapy or radiation?   Have you had surgery on any of the following?   Have you been hospitalized in the last 90 days?   Is there any possibility you could be pregnant? IN/A Currently breastfeeding? IN/A Currently breastfeeding? IN/A Date of your last menstrual period? IN/A Do you have an Advance Directive: ICPR Directive Living Will Power of Attorney ICPR Directive Living Will Power of Attorney ICPR Directive Keight: Height: Signature of patient or person completing form:					-			
Sleep apnea? CPAP? Oxygen at night?   Kidney problems?   Gastrointestinal problems?   Liver problems?   Diarrhea and/or abdominal cramping? For how long?   Thyroid, Parathyroid, or adrenal gland problems?   Cancer treated with chemotherapy or radiation?   Have you had surgery on any of the following?   Have you been hospitalized in the last 90 days?     Currently breastfeeding? IN/A     Currently breastfeeding? IN/A        Currently breastfeeding? IN/A        Date of your last menstrual period? IN/A   Do you have an Advance Directive:   Image: CPR Directive	Supplemental oxygen?							
Kidney problems?   Gastrointestinal problems?   Liver problems?   Diarrhea and/or abdominal cramping? For how long?   Diarrhea and/or abdominal cramping? For how long?   Thyroid, Parathyroid, or adrenal gland problems?   Cancer treated with chemotherapy or radiation?   Have you had surgery on any of the following?   Have you been hospitalized in the last 90 days?     Date of your last menstrual period?   Date of your last menstrual period?   Do you have an Advance Directive:   Cancer treated with chemotherapy or radiation?   Have you been hospitalized in the last 90 days?	Sleep apnea? CPAP? Oxygen at night?							
Gastrointestinal problems?       Do you have an Advance Directive: CPR Directive         Liver problems?       Living Will         Diarrhea and/or abdominal cramping? For how long?       Living Will         Thyroid, Parathyroid, or adrenal gland problems?       Who is your Primary Care Doctor?         Cancer treated with chemotherapy or radiation?       Weight: Height:         Have you had surgery on any of the following?       Signature of patient or person completing form:         Have you been hospitalized in the last 90 days?       Signature of patient or person completing form:	Kidney problems?							
Liver problems?   Diarrhea and/or abdominal cramping? For how long?   Thyroid, Parathyroid, or adrenal gland problems?   Cancer treated with chemotherapy or radiation?   Have you had surgery on any of the following?   Have you been hospitalized in the last 90 days?     Living Will   Dower of Attorney   Other   Who is your Primary Care Doctor?   Who is your Primary Care Doctor?   Weight: Height: Height: Signature of patient or person completing form:								
Diarrhea and/or abdominal cramping? For how long?       Who is your Primary Care Doctor?         Thyroid, Parathyroid, or adrenal gland problems?       Who is your Primary Care Doctor?         Cancer treated with chemotherapy or radiation?       Weight:         Have you had surgery on any of the following?       Signature of patient or person completing form:         Have you been hospitalized in the last 90 days?       Signature of patient or person completing form:					,			
Cancer treated with chemotherapy or radiation?       Weight:         Have you had surgery on any of the following?       Height:         □Heart       □Brain/Spine       □Transplant       □Implants         Have you been hospitalized in the last 90 days?       Signature of patient or person completing form:								
Have you had surgery on any of the following?         □Heart       □Brain/Spine         □Transplant       □Implants         Have you been hospitalized in the last 90 days?    Signature of patient or person completing form:								
Heart       Brain/Spine       Transplant       Implants         Have you been hospitalized in the last 90 days?       Signature of patient or person completing form:					Weight: Height:			
Have you been hospitalized in the last 90 days?								
	Have you been nospitalized in the last 30 days?							
X					X			



## **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.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							

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:	Date:			
RN Signature:	Date:	Patient Identification			