**Pre-Op Admit Orders**

Patient Name: Patient Weight: Surgery Date:

Physician: DX or Procedure:

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergies** | | | |
| ❑ NKDA | | | |
| **Laboratory** | | | |
| ❑ CBC ❑ PT/INR ❑ BMP ❑ Urine HCG ❑Other: | | | |
| **Cardiovascular/X-Ray** | | | |
| ❑ EKG: \_\_\_\_\_To be read by Cardiologist \_\_\_\_\_ Used as Baseline ❑ CXR ❑ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Pre-Op Prep** | | | |
| ❑ Hair Removal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Scrub: \_\_\_\_\_Betadine \_\_\_\_\_Hibiclens \_\_\_\_\_Prevail \_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **DVT Prophylaxis** | | | |
| **❑**Venous Pressure Pumps ❑ Low-Risk Patient/Procedure – NO DVT Prophylaxis ❑ Ted Hose: Thigh High or Knee High | | | |
| **Prophylactic Antibiotic Orders** | | | |
| **Severe Penicillin allergy or cephalosporin allergy (hives, shortness of breath, laryngeal edema, and/or anaphylaxis)**  **❑ Yes or ❑ No**  **NOTE: Adult Indications for using Vancomycin** Physician/APN/PA/Pharmacist documentation of MRSA; High risk due to acute hospitalization within the last year; High risk due to stay in long-term care facility within last year (prior to this admission); Physician/APN/PA/Pharmacist documentation of increased MRSA rate associated with the procedure; Chronic wound care or dialysis; Other physician/APN/PA/Pharmacist documented reason | | | |
| **Surgery** | **Medication** | **Administer within:** | **Redose during procedure** |
| **Hip/Knee Arthroplasty Adult:** | ❑Cefazolin |  |  |
| **Orthopedic/Podiatry** | ❑ For patients < 80 kg, 1 gm IV | 60 mins prior to incision | 4 hrs |
|  | ❑ For patients > 80 kg, 2gm IV | 60 mins prior to incision | 4 hrs |
| **If severe penicillin or cephalosporin allergy administer:** | | |
|  | ❑ Clindamycin 600mg IV | 60 mins prior to incision | 4 hrs |
|  | ❑ Vancomycin 1gm IV (admin over 1 hr) | 2 hours prior to incision | 8 hrs |
| **Pediatric:** | * Ancef \_\_\_\_\_\_\_\_ mg/kg up to \_\_\_\_\_\_\_\_\_\_\_\_ mg * Other: | 60 mins prior to incision | Per Physician |
| **Genitourinary Adult:**  **Transrectal Prostate** | ❑ Levofloxacin 500mg IV (admin over 1 hr) | 2 hours prior to incision | Single-dose only |
| ❑ Clindamycin 600mg IV **AND** Gentamicin 100mg IV | 60 mins prior to incision | 4 hrs |
|  | ❑ Metronidazole 500 mg IV **AND** Gentamicin 100mg IV | 60 mins prior to incision | 6 hrs |
| **Pediatric:** | * Ancef \_\_\_\_\_\_\_\_ mg/kg up to \_\_\_\_\_\_\_\_\_\_\_\_ mg * Other: | 60 mins prior to incision | Per Physician |
| **Head and Neck** **Adult:** | ❑ Cefazolin |  |  |
|  | ❑ For patients < 80 kg, 1 gm IV | 60 mins prior to incision | 4 hrs |
|  | ❑ For patients > 80 kg, 2gm IV | 60 mins prior to incision | 4 hrs |
|  | **If severe penicillin or cephalosporin allergy administer:** | | |
|  | ❑ Clindamycin 600mg IV | 60 mins prior to incision | 4 hrs |
| **Pediatric:** | * Ancef \_\_\_\_\_\_\_\_ mg/kg up to \_\_\_\_\_\_\_\_\_\_\_\_ mg * Other: | 60 mins prior to incision | Per Physician |
| **Other Surgeries** **Adult:** | ❑ Cefazolin |  |  |
|  | ❑ For patients < 80 kg, 1 gm IV | 60 mins prior to incision | 4 hrs |
|  | ❑ For patients > 80 kg, 2gm IV | 60 mins prior to incision | 4 hrs |
|  | ❑ Cefoxitin 2gm IV | 60 mins prior to incision | 2 hrs |
| **\*\*\*\*\*If allergic to PCN, give:** | ❑ Clindamycin 600mg IV | 60 mins prior to incision | 4 hrs |
|  | ❑ Vancomycin 1gm IV (admin over 1 hr) | 2 hours prior to incision | 8 hrs |
|  | ❑ Metronidazole 500mg IV | 60 mins prior to incision | 6 hrs |
|  | ❑ Levofloxacin 500mg IV (admin over 1 hr) | 2 hours prior to incision | Single-dose only |
| **Pediatric:** | * Ancef \_\_\_\_\_\_\_\_ mg/kg up to \_\_\_\_\_\_\_\_\_\_\_\_ mg * Other: | 60 mins prior to incision | Per Physician |
|  | | | |
| **Additional Day of Surgery Orders** | | | |
|  | | | |

Physician Signature Date Time

**SURGERY OR OTHER PROCEDURE**: I, permit Dr.

/ Assistant (as needed) and any other doctors or assistants needed to assist in performing the surgery/procedure my doctor has recommended. An assistant may perform one or all of the following tasks under the supervision of my primary surgeon: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues. The surgery procedure my doctor has recommended is:

**Right / Left**

**THIS SURGERY OR PROCEDURE HAS BEEN RECOMMENDED BECAUSE:**

**MY OTHER TREATMENT OPTIONS INCLUDE:**

I acknowledge that I have read and understand the following risks related to anesthesia. By signing this consent, I allow the use of any anesthetics, sedatives or other medications as directed by my surgeon, anesthesiologist, or certified nurse anesthetist working under the direction of an anesthesiologist that may be necessary. I understand that the administration of anesthesia, including sedation, carries with it certain risks above and beyond those relating to the procedure itself. These risks include, but are not limited to: respiratory (breathing) problems; blood pressure problems; irregular heart beat; irritability; nausea and vomiting; prolonged drowsiness; damage to teeth and/or dental work; unsteadiness; failure to achieve adequate sedation and/or possible awareness or memory of the procedure; allergic or unexpected and possibly severe drug reactions; nerve damage; extended hospital stay and death.

**I UNDERSTAND THAT:**

* Any surgery or procedure and the use of anesthesia have some risks. These risks can be serious and in rare cases result in death.
* Treatment results are not guaranteed and may not cure the condition.
* I consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives, or other appropriate parties approved by my physician(s).
* Medical students may participate in my surgical care under the direct supervision of my physician(s).
* I consent to the disposal of any human tissue or body part which may be removed during the surgery / procedure(s).
* The risks listed below are the more common risks, but are not all the possible risks associated with this operation or procedure.

**RISKS:** The most common risks are bleeding, infection, nerve injury, blood clots, heart attack, allergic reactions and pneumonia. Other risks of this particular operation or procedure include:

**SURGERY PATIENTS:**

If during my surgery the doctor finds an unsuspected medical need, I permit him/her to provide the necessary treatment(s). My doctor has fully explained the surgical procedure in words I understand, I have read and fully understand this consent form, and all of my questions have been answered. **Do not sign unless you have read and thoroughly understand this form.**

Patient/Responsible Party Date Time

Witness Date Time

Physician Date Time

**CONSENT FOR SURGERY**

**OR OTHER PROCEDURE** Patient Identification

**TRANSFUSION CONSENT**

**BLOOD TRANSFUSIONS**

I also understand that I may need to receive blood or blood products while I am in the facility. I understand there are several options I may consider in receiving blood. I may have:

* Blood donated by myself for my own use (self-donated blood).
* Blood donated by friend or family for my use (directed donors).
* Blood currently available to the hospital from other donors (banked blood).
* Other sources are:

**I UNDERSTAND SOME OF THE COMMON RISKS OF RECEIVING BLOOD OR BLOOD PRODUCTS ARE:**

* getting an infectious disease (such as hepatitis or AIDS)
* bad reactions such as: fever, hives, high blood pressure, shortness of breath, and heart or kidney problems.

**I UNDERSTAND THAT:**

* Results of blood transfusions are not always successful and that guarantees cannot be made that the transfusion will help me.
* Losing large amounts of blood may result in death, if blood is not replaced.
* All donors are carefully screened, and all blood is tested thoroughly and properly.
* Blood donated directly for my use by friends or family has NOT been shown to be safer than banked blood.
* If blood I donated to be given back to myself tests positive for AIDS or hepatitis, it will be discarded to protect the health care workers from the hospital.
* If there is not enough donated blood for my use (either self or directed donations), blood from the Blood Bank will be used.
* This consent to blood transfusion(s) is effective throughout this admission.

My doctor has fully explained the possibility of blood transfusion in words I understand. I have read and fully understand this consent form, and all of my questions have been answered. **Do not sign unless you have read and thoroughly understand this form.**

Patient/

Responsible Party Date Time

Witness Date Time

Physician Date Time

**I refuse to receive blood or blood products for any reason. My doctor has explained the likely complications that may occur if I need blood and do not receive it. I will accept all risks associated with my refusal to receive blood and will release my doctor and Harmony Surgery Center, LLC, from any responsibility for any bad results, including my death, which may occur because I refused to accept blood or a blood product.**

(Please put your initials here if refusing blood or blood products.)

Patient Identification

**CONSENT FOR SURGERY**

**OR OTHER PROCEDURE**

**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 OR 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:

Patient Identification

RN Signature: Date:

HARMONY SURGERY CENTER, LLC

Patient Admission Assessment Form

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

***Pre-Operative Instructions for Ambulatory Surgery***

***To prepare yourself for your upcoming procedure, please follow the instructions given below.***

**Please read them *carefully!***

**Patient Name:**

**Date & Time of Procedure:** **Arrival Time:**

* Please arrive at the Harmony Surgery Center **1 HOUR** prior to your scheduled surgery time.
* If you need directions to our facility, please visit our website at www.harmonyasc.com
* Please **bring your insurance card and photo ID with you**. Please bring your eye glasses with you.
* **Do not eat or drink anything** (including water) after midnight the day before your procedure or as directed by your physician. This includes gum, mints, chewing tobacco and marijuana use. This is extremely important and non-compliance could result in cancellation of your surgery.
* **If you are spending the night after your surgery, please bring all of your medications in their original containers.**  Your doctor will advise you whether or not to take your regular medications. If you take the medications, take them with a **small sip of water.** Notify your physician of any prescriptions, over the counter medications, or any herbs you are taking. If you use a CPAP machine at home, please bring it with you.
* Notify your surgeon if you develop symptoms of cold, fever or other illness, as it may be necessary to postpone your procedure.
* Remove make-up and nail polish. Shower the morning of surgery, your physician may also have you perform other cleansing preparations before you arrive for surgery. If having hand surgery, you must remove artificial nails.
* If you have a Medical Power of Attorney of a Legal Guardian, we will need a signed copy of the forms for our records.
* **You must arrange for a ride home in advance!** You will not be permitted to drive or take a cab home. You cannot leave the facility alone. You can only be released in the care of a capable, responsible adult **(must be 18 years of age or older)** who must sign for you and accompany you home. You will receive medications that alter your perception of time. Therefore, after your surgery, you may feel rushed. We will not send you home before it is safe for you to leave the Surgery Center. Expect to be discharged 30-60 minutes after your surgery.
* Leave all jewelry and valuables at home. The Surgery Center cannot be held responsible for them.
* For pediatric patients, it is recommended for a family member to sit with the child in the back seat for the ride home.

**Short Form History and Physical**

**INDICATIONS/SYMPTOMS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST MEDICAL HISTORY,**

**FAMILY & SOCIAL HISTORY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**EXISTING COMORBID CONDITIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DRUG ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICATIONS, DOSAGE & FREQUENCY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PHYSICAL EXAMINATION: BP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **PULSE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NORMAL COMMENTS**

□ **MENTAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

□ **LUNGS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **HEART:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

□ **EXAM SPECIFIC TO PROPOSED PROCEDURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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□ **PATIENT’S GENERAL CONDITION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**ASSESSMENT AND PLAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Patient Identification

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE DATE

White – Medical Records; Yellow – Physician’s Office

S:\HSC\HSC-MED\_REC-FORMS\2017 HSC Clinical Forms\HSC Forms\Short-Form-H&P.docx Rev 1/17