HARMONY SURGERY CENTER, LLC

Patient Admission Assessment Form

Who is taking you home today? (note – you are advised to have a responsible adult with you for 24 hours after procedure**):**

Driver Name: _____ **Driver Phone Number:** _____

**Prior to your discharge, do you grant our staff permission to go over procedural information, medications and discharge instructions 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 Illness Follow-up care Diet/Nutrition 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 Emotional Physical Financial Religion Other:

Pain Evaluation: Current Pain? ☐ Yes ☐ 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.

Health History:	**Yes**	**No**
Seizure/stroke or other neurological problem? Describe:		
Problems with your heart? Describe:		
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, Ibuprofen, etc.)?		
Blood disorder? Describe:		
Autoimmune disorder? Describe:		
Lung problems or problems breathing? Describe:		
Do you currently smoke?		
Have you ever smoked? When did you quit?		
Supplemental oxygen?		
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? ☐Heart ☐Brain/Spine ☐Transplant ☐Implants		
Have you been hospitalized in the last 90 days?		

Heath History Continued:	**Yes**	**No**
Currently have a contagious or infectious condition? Describe:		
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, depression, panic attacks or PTSD?		
Used recreational drug(s) within the last 3 days?		
Smoked or consumed marijuana in the past 3 days?		
Drink alcohol? ☐ Daily ☐ Weekly ☐_____		
Dentures or problems with your teeth?		
Eye or vision problems?		
Hearing problems? ☐ Hearing Aids		
Use wheelchair, walker, cane, etc.?		
Frequent heartburn?		
Object to blood products under any circumstances?		
Problems with anesthesia (self or blood-relative)? Describe:		
Any concerns about anesthesia? Describe:		
Is there any possibility you could be pregnant? ☐N/A		
Currently breastfeeding? ☐N/A		
Date of your last menstrual period? ☐N/A		
Do you have an Advance Directive: ❑ CPR Directive ❑ Living Will ❑ Power of Attorney ❑ Other		
Who is your Primary Care Doctor?		
Weight: **Height:**		
Signature of patient or person completing form: **X**		

Harmony SURGERY CENTER

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:_____

RN Signature: _____Date:_____

Patient Identification