Joint Camp Self-Assessment Form

Name: ______________________________ Surgery Date: _______________________

Who is available to help you at home after your surgery? _______________________

Do you have a preference for a Home Health Agency? _____ If so, which agency? ______

Do you have access to use or borrow any of the following: (please circle)
Walker: wheels? No wheels?  Cane  Shower chair  Bedside commode  Elevated toilet seat

How many outside stairs do you have to get into your home? ______  Hand rail available? ___
How many inside stairs? ______

Do you have access to a bedroom, bathroom & kitchen on 1 level? ______

Have you ever had knee or hip joint replacement before? ______
If yes, what joint? ______  When? ______  What hospital? _______________________

What is your occupation? __________________  If retired, former occupation? __________

Are you currently taking narcotic pain medication to help manage your pain? (Percocet, Vicodin, MS Contin, oxycontin, etc.) If so, what is the name and dosage of the medicine?
_____________________________________________________________________________

What goals do you want to achieve by having this surgery?

Sleep Apnea Survey

Height_______  Weight_______  (BMI_______ to be determined by staff)

Are you Male?  ___Yes  ___No

If Male, is your neck circumference greater than 17 inches? ___Yes  ___No

If Female, is your neck circumference greater than 16 inches? ___Yes  ___No

Do you snore louder than talking or than can be heard through a closed door? ___Yes  ___No

Do you often feel tired, fatigued, or sleeping during the daytime? ___Yes  ___No

Has anyone observed you stop breathing during your sleep? ___Yes  ___No

Do you have or are you being treated for high blood pressure? ___Yes  ___No

Are you over 50 years old? ___Yes  ___No

___  High Risk for Sleep Apnea  (to be determined by staff)

Sentara Martha Jefferson Hospital
Anesthesia Questionnaire
Page 1 of 2

Date of Surgery | Surgeon | Type of Surgery
---|---|---

Patient Name | DOB | □ Male | □ Female | Height | Age | Weight | BMI

Form Completed By | Date/Time | Relation to Patient

PCP | Last Visit | Specialist(s) | Last Visit

Yes No
□ Previous surgery/anesthesia? List what & when ___________________________________________________________________
□ Have you, or a blood relative, had any problems with anesthesia, including: nausea, weakness, difficulty breathing or high fever? If yes, explain ___________________________________________________________________

Yes No
□ Premature birth
□ Breathing problems after birth
□ Other conditions being treated for:

For Children under Age 18:

Yes No
□ Heart problems after birth
□ Respiratory illness in past month
□ Family history of muscle disease

For All Patients:

Yes No
□ Heart attack-when
□ Heart surgery-what & when
□ Pacemaker/internal defibrillator
□ Congestive heart failure
□ Angina/chest pain
□ Heart murmur requiring treatment
□ Irregular heart beat
□ Last EKG: when & where?
□ High blood pressure
□ Elevated Cholesterol
□ Fainting spells
□ Shortness of breath
□ Asthma/wheezing
□ Pneumonia in last 12months
□ Emphysema/chronic bronchitis or/lung disease/COPD
□ Snore
□ Been told you stop breathing while you sleep
□ Frequent morning headaches or fall asleep easily during the day
□ Sleep apnea
□ Use or been prescribed CPAP/BiPAP machine
□ Back/neck surgery or problems
□ Arthritis requiring treatment
□ Problems opening mouth (TMJ)
□ Numbness/weakness of muscles where ____________________________

What is the most activity you can do before you get tired or short of breath and have to stop?
□ Walk across room □ Walk one block □ Walk one mile □ Run a mile

If one block or less, what limits your activity? ____________________________

Any other information you feel the anesthesiologist should know? ____________________________

Phone number(s) where nurse or anesthesiologist may reach you (the patient)

Home ____________________________ Cell ____________________________ Work ____________________________

Questions or Concerns, please call (434) 654-8237
PASS Fax (434) 654-8239

Complete both sides and leave with Surgeon’s Office or fax to 434-654-8239
(Patient or Family to complete)
Pre-Anesthesia Patient Medication List/Discharge Instructions – Anesthesia Pre-Op Questionnaire – Page 2

Full Name ___________________________ Date of birth _________________________  

Date this list was written ____________ Written by: ☐ Patient ☐ Spouse ☐ Other ____________ ☐ Refer to Patient’s Home Medication List (send with this form)  

1. **Allergies:** ____________  
   2. Please list below all medicines you have taken or have been prescribed for you within the last two weeks including prescriptions, over the counter, vitamins, herbal supplements, drug patches, inhalers, eye drops, etc.  

### PATIENT: FILL IN THIS SECTION ONLY – PLEASE PRINT  

<table>
<thead>
<tr>
<th>Name of medicine (examples: Norvasc, multivitamin …)</th>
<th>Dose or Amount (5 mg, 1 tab…)</th>
<th>How Often (once daily …)</th>
<th>What time do you take each dose?</th>
<th>HOW you take this (by mouth, inhaler …)</th>
<th>STAFF USE ONLY DATE AND TIME OF LAST DOSE (to be completed on arrival for procedure)</th>
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**Staff Use Only: At admission above list reviewed with patient/representative on ___________________ (date) by ___________ (initials)**  

FOR SAME DAY SURGERY ONLY – to be completed by physician  

<table>
<thead>
<tr>
<th>POST PROCEDURE PRESCRIPTIONS OR MEDICATION CHANGES</th>
<th>GIVEN TO PATIENT</th>
<th>LEFT ON CHART</th>
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<tr>
<td>Medication</td>
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**Staff Use Only: At discharge above list reviewed with patient/representative on ___________________ (date) by ___________ (initials)**  

Physician Signature ___________________________ Date ___________ Time ___________
Total Joint Surgery Pre-Surgery Freedom of Choice Form

1. Do you have a preference of which homecare agency provides therapy and nursing care in your home after surgery?

   Yes or No (circle answer)

   If Yes, which agency do you prefer? ________________________

   If No, a referral will be sent to an agency in-network with your insurance.

2. What is your primary insurance company? ________________

   Comments: ___________________________________________________

   __________________________________________________________________

Answer this next question ONLY if there is the possibility of not going home after surgery

3. Which Skilled Nursing Facility do you prefer to go to if you are unable to go home after surgery?

   1st Choice ______________________________________

   2nd Choice ______________________________________

Patient Signature ____________________________ Date_______ Time_______

OR Representative ____________________________ Date_______ Time_______

This is a pre-surgery planning form and is not part of your permanent record. Signing this form gives permission for Sentara Martha Jefferson Hospital & your surgeon’s office to send your information to the agencies/facilities noted above. Your final discharge plan will be confirmed in the hospital after surgery.

Patient Name & DOB ____________________________________________