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)**

Adapted from **STOP Questionnaire**. *A Tool to Screen Patients for Obstructive Sleep Apnea*. F. Chung F.R.C.P.C. et al. Anesthesiology 2008; 108:812-21. The American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.

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SENTARA
eCare Health Network

Patient Label

Sentara Martha Jefferson Hospital
Anesthesia Questionnaire

ANES

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

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 _____

For Children under Age 18:
Yes No
☐ ☐ Premature birth
☐ ☐ Breathing problems after birth
☐ ☐ Other conditions being treated for:

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
_____

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

Yes No
☐ ☐ Chronic Pain
☐ ☐ Thyroid Disorder
☐ ☐ Stroke-when_____ Deficits?_____
☐ ☐ Seizures-type_____
☐ ☐ Frequent heartburn, hiatal hernia, reflux
☐ ☐ Motion Sickness
☐ ☐ Diabetes/glucose intolerance
avg. morning blood sugar _____
☐ ☐ Bleeding problems
☐ ☐ Blood Clots
☐ ☐ Sickle cell disease or trait
☐ ☐ Hepatitis or jaundice
☐ ☐ Cancer-of what & when _____
☐ ☐ Kidney disease
☐ ☐ Dialysis
☐ ☐ Mediport, portacath, vein shunt
☐ ☐ Prosthesis/implants _____
☐ ☐ Body piercings/jewelry
☐ ☐ Have a communicable disease (i.e. TB, HIV,VD, hepatitis, MRSA, VRE, etc.)
☐ ☐ Are you pregnant?
☐ ☐ Smoke: packs per day _____
☐ ☐ Ever smoked in the past? Quit when? _____
☐ ☐ Drink alcohol regularly/how much? _____
☐ ☐ Object to blood transfusions
☐ ☐ Dentures/partials/loose or chipped teeth
☐ ☐ Other conditions being treated for _____
☐ ☐ If hospitalized in last 12 months reason:_____

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 _____

SENTARA
eCare Health Network

Patient Label

Sentara Martha Jefferson Hospital
Anesthesia Questionnaire

(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					*STAFF USE ONLY DATE AND TIME OF LAST DOSE (to be completed on arrival for procedure)*
Name of medicine (examples: Norvasc, multivitamin ...)	**Dose or Amount** (5 mg,1 tab...)	**How Often** (once daily …)	**What time do you take each dose?**	**HOW you take this** (by mouth, inhaler …)	

*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 POST PROCEDURE PRESCRIPTIONS OR MEDICATION CHANGES				*GIVEN TO PATIENT*	*LEFT ON CHART*
Medication	Dose	Frequency	Instructions for use		

*Staff Use Only: At **discharge** above list reviewed with patient/representative on*_____ *(date) by*_____*(initials)*

Physician Signature_____ Date _____ Time _____

SENTARA®

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 _____