EDWARDSVILLE AMBULATORY SURGERY CENTER □ SUICIDE RISK
OUT-PATIENT NURSING ASSESSMENT □ FALL RISK

Patient Name: _____

Info. Obtained From: □ **Patient** □ **Other** _____

Stated Reason for Admission: _____

_____

Primary Physician: _____
Phone number: _____

MEDICAL HISTORY: **Height**_____ **Weight**_____**lb.**
□ **Heart Disease** □ **CHF** □ **M.I.** □ **C.A.D.** □ **Irregular rhythm**
□ **Mitral Valve Disease - Antibiotics with dental** □ **Yes** □ **No**
□ **Lung Disease** □ **Asthma** □ **C.O.P.D.**
□ **Liver Disease** □ **Hepatitis** □ **Cirrhosis**
□ **Kidney Disease** □ **Dialysis**
□ **CVA/blood clots/TIA**
□ **Diabetes** □ **MRSA/ VRE/ C-Diff/infectious**
□ **Hypertension** **diseases/HIV/hepatitis**
□ **Cancer** _____
□ **Seizures/passing out spells**
□ **Thyroid Disease**
□ **Arthritis** □ **Schizophrenia**
□ **Bleeding Disorder** □ **Depression** □ **Anxiety**
□ **GERD/reflux/ulcers/hiatal hernia**
□ **Sleep Apnea/ CPAP**
□ **Pacemaker If yes, Model**_____
□ **Negative Health History**
□ **Comments**
□ **LMP**_____

PREVIOUS SURGERIES

_____
_____
_____
_____

***Have they had a prior colonoscopy? Yes / No**
If yes: with biopsy/polyps Yes / No
If yes: was it 3 or more years ago? Yes / No

*** Any patient/ family history of problems with anesthesia?**
□ **Yes** □ **No** **If yes, explain:**
_____

Advance directive/living will: Yes / No; If yes: bring copy

PREOPERATIVE TESTING: Where:_____
□ **Labs Abn** □**EKG: Abn** □ **CXR: Abn**
□ **Patient Covid-19: Neg / Pos / N/A Date/initial:**_____
□ **Required Visitor/Parent Covid-19: Neg / Pos / N/A**
- Abnormal results reported to: □ **anesthesia**
□ **surgeon** □ **primary** □ **other** _____

Contact/Transport Person (Day of OR) & Phone#: _____
_____**Password-**_____
Release Information? □ **Yes** □ **No**

NUTRITION
Special Diet □ **Yes** □ **No** **If yes, Type** _____
General Appetite: □ **Good** □ **Fair** □ **Poor**

DISEASE SCREENING: **In last 30 days you/immediate family have:** □ **traveled to a high risk area** □ **been in contact with someone suspected or known covid-19 positive *AND*** □ **have a fever** & lower resp. distress ; □ ***NO Indications***

RECURRING VISITS: **DATE/SIGNATURE**
□ **FORM REVEIWED AND UPDATED** _____

□ **FORM REVEIWED AND UPDATED** _____

□ **FORM REVEIWED AND UPDATED** _____

PREOPERATIVE INSTRUCTIONS:
Arrival Time: _____ **A.M.** __ **P.M.** __
Directions to EASC given ____
___ NPO after midnight (for children see order sheet) before surgery; take circled meds below morning of surgery(No gum, hard candy, mints, smoking/vaping/chewing tobacco, etc).
___ Wear loose clothing. If you do not wear cotton underwear, you will be required to remove.
___ Bath/shower with anti-microbial soap (no lotion) night prior and a.m. on DOS.
____ No jewelry/body piercings; cell phones not allowed in care areas.
___ Leave valuables at home (bring photo identification, insurance cards, and any forms.
___ No nail polish.
___ If child, may bring special item.
___ Pt. informed they must be taken home from center by an adult.
____**Covid-19 test must be done 72 hours prior to DOS. Date to get nasal swab** _____**.**
____**Review the signed EASC patient requirement/education form.**
____**Upon arrival to parking lot, need to call 618-656-8200 and let us know. You will wait in car until we call you to enter due to limited seating.**

PHYSICAL-SENSORY LIMITATIONS/ HANDICAPS
MENTAL STATUS: □ **Alert/ Oriented** □ **Other**_____
SUICIDE RISK: Have you had thoughts of suicide? □ **NO** □**YES**
If yes: □**any now** □**hurt self/others** □**previously attempted**
VISION: □ **Glasses/ Reading** □ **Contact Lenses** □ **IOL**
HEARING: □ **Hard of Hearing** □ **Hearing Aid R L**
DENTURES: □ **Full** □ **Partial** □ **Braces** □ **Crowns**
□ **Chipped Teeth** □ **Loose Teeth** □ **Edentulous**
FALL RISK: □ **Fallen in the last year** □ **Feels at risk for falling**
□ **> 85 years old** □ **Has trouble dressing/grooming/bathing.**
□ **Speech Impairment** □ **O2 Support** □ **Language Barrier**
□ **Cane** □ **Crutches** □ **Wheelchair** □ **Walker**
□ **Other** _____ □ **N/A**

HABITS OF DAILY LIVING
Smokes: □ **No** □ **Yes-** ____**PPD** _____**year(s)**
Alcohol: □ **No** □ **Daily** □ **Weekly** □ **Occasional**
Drug Hx: □ **Yes** □ **No**

PAIN ASSESSMENT □ **NO PAIN**
*** Pain Scale: 1=No Pain 5=Moderate Pain 10=Severe Pain**

Current Level of Pain= 1 2 3 4 5 6 7 8 9 10
Location: _____
Intensified by: _____
Relieved by: _____
Current Pain Med: _____**How often:** _____
Pain Goal: _____

DATE/TIME **NURSING NOTES**
_____
_____
_____
_____

Date/Time_____ **Interviewed by:** _____

EDWARDSVILLE AMBULATORY SURGERY CENTER
OUT-PATIENT NURSING ASSESSMENT

□ **SUICIDE RISK**

□ **FALL RISK**

***Complete This Section Age 17 and Under Only!**
PEDIATRIC/ ADOLESCENT ADDENDUM

Age: _____ **Current Grade:** _____

Nickname: _____

Legal Guardian: _____

□ **Informed Legal Guardian they must be present at all times the day of Surgery and provide legal authorization (if applicable).**

Are there any Special Custodial Concerns? □ **Yes** □ **No**

Head Circumference if child less than 6 months_____ □ **N/A**

Immunizations Up to Date: □ **Yes** □ **No**

History of Childhood Illnesses:

- □ **Measles/ 3 Day Measles**
- □ **Mumps**
- □ **Chicken Pox**
- □ **Scarlet Fever**

√ **Check Mark Indicates Presence, A Positive Finding Or A Specific Observation**

DATE/TIME **Nursing Notes**