

☛ **DO YOUR PART TO PREVENT SURGICAL INFECTIONS** ☛

PLEASE, read through these instructions and ask your surgeon if you have any questions.

Here are some best practice actions. **Take these actions BEFORE** coming to the Bend Surgery Center for a planned surgery. Share these actions with people you know who have a surgery planned.

- Bathe the night before surgery and the morning of surgery. Bathing will lessen the number of germs on your skin.
- You may be given a bathing product with *chlorhexidine gluconate* in it. Follow the instructions and be sure to use it.
- Wear a clean set of pajamas. Sleep on clean sheets. Wear clean clothes after your morning bath.
- **Do you have Diabetes?** Try to keep your blood sugars at an average of at least 170 or lower. High blood sugars can lessen your body's natural healing responses. This could slow wound healing. Contact your Primary care physician if you have questions about medication changes.
- **Do you smoke?** Stop smoking 4 weeks before surgery. Smoking tightens you blood vessels. Your surgical wound may not get enough blood flow and prevent oxygen and germ fighting agents to get to the wound.
- **Are you overweight?** If you are 20-30 lbs. overweight you are at a higher risk for surgical site infection. Talk to your doctor about going on a proper diet and exercise program before surgery.
- Wash your hands often. This helps lessen the amount of germs on your hands that could pass to the surgical site *before* and ***after surgery***.
- **Never touch your wound or dressings without having washed your hands first with soap & water for 15 seconds.**

For more information on Surgical Site Infection Prevention, go to: http://www.shea-online.org/Assets/files/patient%20guides/NNL_SSI.pdf

DATE OF PROCEDURE _____

PATIENT NAME _____ DOB _____ SURGEON _____

PROCEDURE _____ PRIMARY CARE DR. _____

PHONE (home) _____ (work) _____ (cell) _____

PHONE # TO REACH YOU THE DAY BEFORE YOUR PROCEDURE _____ DAY OF PROCEDURE _____

HEIGHT _____ WEIGHT _____

PERSON DRIVING YOU HOME _____ PHONE _____

EMERGENCY CONTACT _____ LEARNING PREFERENCES WRITTEN VERBAL

MAY WE LEAVE A MESSAGE ON YOUR MACHINE? YES NO N/A IF YES, MAY WE LEAVE INFORMATION REGARDING YOUR MEDICAL PROCEDURE? YES NO

RECEIVED THE NOTICE OF RIGHTS / PRIVACY PRACTICES BOOKLET.

DO YOU HAVE A SIGNIFICANT HISTORY OR CURRENTLY HAVE: Please check Yes or No for both columns and circle what applies.

	YES	NO		YES	NO
Neuro	<input type="checkbox"/>	<input type="checkbox"/>	Seizures _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Strokes, TIAs - R / L side affected	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Black out spells	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Numbness, weakness or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack, Cardiac Bypass _____ vessels	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains (angina)	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat; pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur, leaky valve - mitral / aortic, no symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Lung	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath - with exercise only	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Frequent bronchitis or pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	TB or other lung problems	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Recent cold or infection, or MRSA When _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Open wounds, sores, rashes	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Other medical problems or comments _____	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/>	<input type="checkbox"/>	Hiatal hernia or heart burn, GERD
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer disease
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis - Type A, B, or C / When _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or urination problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Other abdominal problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: Type I / Type II
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or other gland problems
<input type="checkbox"/>	<input type="checkbox"/>	Anemia, bleeding or other blood problems
<input type="checkbox"/>	<input type="checkbox"/>	HIV disease
<input type="checkbox"/>	<input type="checkbox"/>	Artificial or limited movement of joints R / L _____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Problems with any prior anesthesia? Nausea / vomiting / trouble waking up
<input type="checkbox"/>	<input type="checkbox"/>	Do you have airway problems? Sleep apnea / CPAP / BiPAP
<input type="checkbox"/>	<input type="checkbox"/>	Have you been told you have a difficult airway at surgery?
<input type="checkbox"/>	<input type="checkbox"/>	Limited mouth opening or neck movement
<input type="checkbox"/>	<input type="checkbox"/>	Blood relatives with life threatening anesthesia problems
<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness, anxiety attacks or claustrophobia
<input type="checkbox"/>	<input type="checkbox"/>	Dental plates ↑ ↓ partial / permanent, loose / chip / crowns / capped teeth

Do you smoke? # _____ yrs smoked # _____ packs per day (If you are a former smoker, what year did you quit? _____)

Do you drink alcohol? _____ per day _____ per week Rarely Occasionally

Do you use recreational drugs? _____

Do you have: Glasses, Contacts, Hearing aid(s), Physical aids (e.g., cane) _____

Implanted Cardiodefibrillator _____ Implanted Metal _____

Do you have any cultural / religious beliefs that may affect our providing health care? N/A or Explain _____

FEMALES: Are you pregnant? Yes No, willing to sign a waiver Need blood test Hysterectomy Menopause > 2 yrs

Are you currently breast feeding? YES NO

Please list your previous operations _____

PLEASE HAVE SOMEONE AVAILABLE TO CARE FOR YOU THE FIRST 24 HOURS AFTER SURGERY.

Patient Signature _____ Date _____

(Relationship if not patient _____)

X _____ (Nurse's Signature) _____ (Date) _____ (Time)

**PATIENT
 LABEL
 HERE**



P.O. Box 6329
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Phone (541) 318-0858
Fax (541) 318-0857

INSURANCE VERIFICATION

Patient Name _____ Procedure Date _____ Birth Date _____

Primary Insurance Co. _____

Insurance Co. Address _____

Subscriber ID _____ Group # _____

Subscriber Name _____ Birth Date _____ Employer _____

Secondary Insurance Co. _____

Insurance Co. Address _____

Subscriber ID _____ Group # _____

Subscriber Name _____ Birth Date _____ Employer _____