Doctor's History and Physical
Pre-operative Forms

FORT WHYTE
ORTHOPEDICS
RESTORING *motion* FOR LIFE

FORT WHYTE ORTHOPEDICS
304-1020 LORIMER BLVD
WINNIPEG, MB R3P 1C7
PHONE: 204-560-2272
FAX: 204-815-5755
EMAIL: info@fortwhyteorthopedics.com

Dear Primary Care Provider,

RE:

Your patient mentioned above is on a wait list for surgery at

Please keep this surgical package in the patient's records until the patient schedules a Preoperative History and Physical. See attached for detailed instructions.

The completed forms must be submitted a minimum **TWO MONTHS prior to the surgery date** ***(unless told otherwise)***. Upon completion, the surgical package can be faxed or emailed to the information on the letterhead.

Patients who have any missing pieces of the surgical package will be contacted and failure to submit the completed surgical package by the due date will result in delaying surgery.

Thank you for your time and cooperation.

Sincerely,

Fort Whyte Orthopedics

FORT WHYTE ORTHOPEDICS
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Attached is the <u>Pre-Op History and Physical</u>

- ➔ **These forms must be completed by a family doctor or nurse practitioner**
- ➔ **Please ensure preoperative tests are performed based on the surgery categories below:**

MINOR SURGERY

- ❑ Note: Preoperative tests are rarely indicated for asymptomatic patients undergoing minor surgery.*

MAJOR SURGERY

- ❑ **Patient is 16 - 49 years of age.**

  Order: CBC. Other tests may be indicated*

- ❑ **Patient is 50 years of age or older.**

  Order: CBC; ECG Cr/eGFR; and NA, K, TCO, *Other tests may be indicated.**

*Additional tests may be appropriate for patients with complex or uncommon surgical or medical conditions. Apply clinical judgment as required. To access the Consult the Routine Preoperative Lab test Guidelines documents, please visit: wrha.mb.ca/extranet/eipt/EIPT-003.php

***NOTICE: CHEST X-RAYS ARE NOT RECOMMENDED FOR ANY SURGERY except** to facilitate diagnosis of new/worsened symptoms, or if ordered by the surgeon in the work up of malignancy.*

Please submit the completed forms minimum **<u>TWO MONTHS prior to the surgery date</u>** ***(unless told otherwise)***

If you have any questions please contact the Surgeon's Office Assistant (SOA):

The completed forms are DUE on: _____

- *Patients who have any missing pieces of the surgical package will be contacted.*
- *Failure to submit your completed surgical package by the due date will result in delaying surgery.*

WRHA SURGERY PROGRAM

PREOPERATIVE History & Physical Form

This form must be submitted to site at least 14 days prior to surgery date. Failure to do so may result in cancellation.

ENSURE ALL CONTACT INFORMATION ON BOOKING CARD IS CORRECT.

Preoperative Testing App:

Patient Name:

D.O.B.

PHIN/MHSC:

Address:

H: C: W:

Please Fax to: ☐ PAC Department Facility Fax # |_|_|_|-|_|_|_|-|_|_|_|_| ☐ Surgeon's Office Fax # |_|_|_|-|_|_|_|-|_|_|_|_|

Diagnosis _____

Proposed Procedure _____ Proposed Date |_|_|_|_|_|_|_|_| D D M M M Y Y Y Y

PART A – ALERTS	No	N/A	Yes	Describe (e.g. reason, language, details)
A1. Patient Requires a Proxy	☐		☐	☐ Name _____ Reason _____
A2. Interpreter Required	☐		☐	☐ Language _____
A3. Previous Difficult Airway	☐		☐	☐ Describe, and identify facility of event _____
A4. Known/Suspected Obstructive Sleep Apnea	☐		☐	☐ Clinically Suspected/Assessment Pending _____ ☐ Diagnosed/Severity _____ CPAP Compliance: ☐ No ☐ Yes ☐ N/A
A5. Adverse Reaction to Previous Anaesthetic (patient or relative)	☐		☐	☐ Describe _____
A6. Previous Adverse Reaction to Transfusion	☐		☐	☐ Describe _____
A7. Blood Borne Infections	☐			☐ Hepatitis B Virus ☐ Hepatitis C Virus ☐ Human Immunodeficiency Virus
A8. Other Alerts	☐			☐ Methicillin-resistant Staphylococcus aureus ☐ Clostridium difficile Tuberculosis (TB): ☐ Active TB ☐ Latent TB ☐ Other, Describe: _____
A9. Allergies ☐ See attached*	☐		☐	☐ (include type of reaction) _____

PART B – HISTORY	No	N/A	Yes	Describe (e.g. type, quantity, frequency)
B1. Tobacco Use	☐		☐	*Pack years* _____ *Date quit* |_|_|_|_|_|_|_|_| D D M M M Y Y Y Y
B2. Vaporizer/e-cigarette use	☐		☐	_____
B3. Recreational Drugs	☐		☐	_____
B4. Alcohol Consumption	☐		☐	_____
B5. Previous or Current Steroid Therapy	☐		☐	_____
B6. Date of Last Menses	☐			|_|_|_|_|_|_|_|_| D D M M M Y Y Y Y
B7. Pregnancy Test	☐		☐	*If done, results:* _____

B8. Medical History (please indicate stable or acute) ☐ See attached*

_____

_____

_____

_____

_____

_____

_____

B9. History of Present Illness

_____

_____

_____

B10. Surgical History ☐ See attached*

_____

_____

_____

B11. Medications ☐ No ☐ Yes (Describe)

☐ Medication Reconciliation attached (check box)

☐ See attached*

_____

_____

_____

_____

_____

_____

* Do not attach extensive encounter notes

WRHA SURGERY PROGRAM

PREOPERATIVE History & Physical Form

This form must be submitted to site at least 14 days prior to surgery date.
Failure to do so may result in cancellation.

ENSURE ALL CONTACT INFORMATION ON BOOKING CARD IS CORRECT.

Patient Name:

D.O.B.

PHIN/MHSC:

Address:

H: C: w:

PART C – PHYSICAL (Note any active or unstable system findings)

Height _____ cm Weight _____ kg Body Mass Index (BMI) _____ Blood Pressure _____ Heart Rate _____ SpO_2 _____

CHEST (other)**:** Rhythm _____ Murmurs _____ Air Entry _____ Adventitious Sounds _____

HEAD & NECK: _____ Neck circumference _____ cm

ABDOMEN: _____ **EXTREMITIES:** _____

PART D – REVIEW OF SYSTEMS *Please note abnormal findings below and indicate associated code number (e.g. "D3" for Respiratory)*

	#	
D1. Central Nervous System		
D2. Cardiovascular		
D3. Respiratory		
D4. Genitourinary		
D5. Haematologic & Lymphatic		
D6. Endocrine & Metabolic		
D7. Gastrointestinal		
D8. Neuromuscular		
D9. Dermatologic		
D10. Other		

PART E – OPTIMIZATION

Blood Management Service

☐ Consult initiated
Consider referral if major surgery and anemia, rare blood type, multiple antibodies or patient refuses blood transfusion
www.bestbloodmanitoba.ca 204-787-1277

If possible, please address with the patient any of the following applicable items to reduce the risk of postoperative complications:

Healthy Behaviours
- Active lifestyle
- Healthy diet
- Reducing excessive alcohol use
- Recreational drug cessation
- Smoking cessation

Chronic Diseases Management
- Diabetes screening/Blood glucose control
- COPD/Asthma
- Hypercholesterolemia
- Hypertension
- Malnutrition
- Nutritional Anemias

PART F – LABORATORY SCREENING (patients at least 16 years of age)

☐ Check if indicated test results are attached.

A guideline based app to determine which tests are required is available at: logixmd.com/preop

TESTS WITHIN 6 MONTHS OF SURGERY
are valid, provided there has been no interim change in the patient's condition.

CLINICAL JUDGEMENT IS REQUIRED
as additional tests may be appropriate for some patients.

GUIDELINE DOES NOT APPLY TO
patients undergoing cardiac surgery or cesarean section

Chest X-rays – *Not recommended* for **any** surgery *except* to facilitate diagnosis of new/worsened symptoms, or if ordered by the surgeon in the work up of a malignancy.

FOR MINOR SURGERY*

DO NOT ORDER PREOPERATIVE TESTS
in asymptomatic patients.

* Associated with an expected blood loss of less than 500 mL, minimal fluid shifts and is typically done on an ambulatory basis (day surgery/same day discharge)*. It includes cataract surgery; breast surgery without reconstruction; laparoscopic cholecystectomy and tubal ligation; and most cutaneous, superficial, endoscopic and arthroscopic procedures.

***‡Access the complete adult preoperative lab test guideline** – including lists of major and minor surgery, at http://www.wrha.mb.ca/extranet/eipt/EIPT-003.php*

FOR MAJOR SURGERY** If age (years) is:

16 - 49: Order **CBC**. Additional tests may be indicated for comorbid diseases. Consult guideline.‡
50+: Order **CBC, *ECG, Na^+, K^+, Cl^-, TCO_2, CR/eGFR***

Major Surgery: Other tests to consider
- **Oral Corticosteroids, DM** or **BMI greater than 40**: add Hemoglobin A1C or fasting plasma glucose.
- **Malnutrition, BMI greater than 40,** or **Liver disease**: AST, ALT, Alk Phos, GGT albumin, total and direct bilirubin & INR.
- **At high risk for iron deficiency**: add serum iron TIBC and Ferritin.
- **Thyroid disease**: add TSH.

** Associated with an expected blood loss of greater than 500 mL, significant fluid shifts and typically, at least one night in hospital^. Includes laparoscopic surgery (except cholecystectomy and tubal ligation), open resection of organs, large joint replacements, mastectomy with reconstruction, and spine, thoracic, vascular, or intracranial surgery.

^ *If the surgery is typically ambulatory but the patient has a medical or social reason for overnight admission (i.e. OSA, no support at home), still consider the surgery minor in determining which lab tests to order.*

Examining Provider: _____ (SIGNATURE) _____ (PRINTED NAME AND DESIGNATION) Examination Date: D D M M M Y Y Y Y

Address: _____ Phone: ___-___-____ Fax: ___-___-____

☐ It is not necessary to repeat history and physical as no significant change noted in the patient's health status since the last examination.

Examining Provider: _____ (SIGNATURE) _____ (PRINTED NAME AND DESIGNATION) Reassessment Date: D D M M M Y Y Y Y

Comments: _____

Patient's Questionnaire and Pre-Admission Form

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The following paperwork is to be filled out by the patient:

- ❑ WRHA SURGERY PROGRAM PRE-Operative Assessment Patient Questionnaire (4 pages)

- ❑ PRE-ADMISSION FORM (1 page)

- ➔ The forms mentioned above can be sent back to the office by email or fax (see letterhead)

Please submit the completed forms minimum **TWO MONTHS prior to your surgery date** ***(unless told otherwise).***

If you have any questions please contact your surgeon's office assistant (SOA):

SOA:
Phone:
Email:

The completed forms are DUE on: _____

- *Patients who have any missing pieces of the surgical package will be contacted.*
- *Failure to submit your completed surgical package by the due date will result in delaying surgery.*

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

WRHA SURGERY PROGRAM
PREoperative Assessment
Patient Questionnaire

DATE COMPLETED (DD/MMM/YYYY): _____
PHIN: _____

Please fill out this form (questions 1 - 33) to help our Health Care Team meet your medical needs.
Print your answers in black ink; you will need to mail or drop off your completed form to your surgeon's office.
This information is needed at least 3 weeks before your surgery date.

1. Legal Name: _____ (SURNAME) _____ (MIDDLE) _____ (FIRST) _____ (PREFERRED NAME)
2. How old are you? _____
3. Home #: _____ Cell #: _____ Alternate #: _____
4. Date of Surgery (DD/MMM/YYYY) _____ Surgeon's Name: _____
   Type of Surgery: _____
5. Do you have a Health Care Directive? ☐ No ☐ Yes ☐ Copy attached
   Power of Attorney: _____ Phone #: _____
6. a) What language do you speak/understand? ☐ English ☐ French ☐ Other _____
   b) Will you need an interpreter? ☐ No ☐ Yes
7. Contact Person: _____ Relationship: _____ Phone #: _____
   Alternate #: _____
8. Who will pick you up from the hospital on discharge?
   Name: _____ Relationship: _____ Phone #: _____
   Alternate #: _____
9. a) Have you been hospitalized for more than 24 hours or spent more than 24 hours in an Emergency Department in the past 6 months:
   ☐ In an acute care hospital outside Manitoba ☐ In an acute care hospital within Winnipeg
   b) Have you been hospitalized or investigated for the following in the past 6 months?
   ☐ Tuberculosis (TB) ☐ *C. difficile* ☐ MRSA
   ☐ Other Describe: _____ ☐ Do not know
10. Do you have Allergies and/or intolerances (i.e. medication, latex, tape,dust/pollen,food,etc.)
    ☐ No ☐ Yes List below:

Allergic to:	Reaction:

11. Do you wear a **Medic Alert® Bracelet** . . . . . ☐ No ☐ Yes
    What does it say? _____
12. List Home Medications or attach a copy of your medication list ☐ Copy attached
    - Prescription medications (i.e. birth control pills, creams, eye drops, inhalers, insulins, patches, sleeping pills, etc.)
    - Over the counter medications (i.e. aspirins, cold/allergy drugs, laxatives, vitamins)
    - Herbs or others (i.e. garlic, gingko biloba, St. John's Wort)

Drug Name	Dose (grams or mg)	How Often	Reason

If coming to the PREoperative Assessment Clinic, please bring the containers of all prescription and over the counter medications with you.

Hospital Use Only

Interview Information

T _____ P _____ RR _____

☐ Right Arm
BP _____ ☐ Left Arm

O_2 SATS _____

Weight _____ Height _____

BMI _____

☐ Surveillance swab sent (if indicated)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ Medication Reconciliation Completed for Same Day Admission

☐ Best Possible Medication History Completed for Day Surgery Patient with Chronic Renal Failure on Hemodialysis

_____

Patient Name: _____ **PHIN:** _____

13. Family Doctor's Name: _____ Phone #: _____
Date of last visit: (DD/MMM/YYYY) _____ Reason: _____

14. Do you see a Specialist Doctor (heart, lung, blood, etc.) ☐ No ☐ Yes
List below:
Doctor's Name: _____ Phone #: _____
Date of last visit: (DD/MMM/YYYY) _____ Reason: _____
Doctor's Name: _____ Phone #: _____
Date of last visit: (DD/MMM/YYYY) _____ Reason: _____

15. Is it possible that you could be pregnant? . . . . . ☐ No ☐ Yes

16. How tall are you? _____ How much do you weigh? _____ lbs or kgs

17. a) Do you have Obstructive Sleep Apnea (OSA)? . . . . . ☐ No ☐ Yes
b) Have you had a sleep study? . . . . . ☐ No ☐ Yes
c) Do you use a CPAP/BiPAP machine? . . . . . ☐ No ☐ Yes
d) Do you snore loudly (loud enough to be heard through closed doors)? . . . ☐ No ☐ Yes
e) Do you think you have abnormal or excessive sleepiness during the day? . . ☐ No ☐ Yes
f) Has anyone noticed that you momentarily stop breathing during your sleep?. . ☐ No ☐ Yes
g) Is your neck measurement greater than 40 cm/16 inches? . . . . . ☐ No ☐ Yes

18. a) Do you get short of breath or tightness in your chest lying flat in bed or getting dressed? . . . . . ☐ No ☐ Yes
b) Can you climb 1 flight of stairs without stopping to rest? . . . . . ☐ No ☐ Yes ☐ Haven't tried this activity

19. Health History: Place a mark (X) if you have had any of these ☐ None

- ☐ Chest Pain
- ☐ Angina/Heart Related Chest Pain
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart beats fast, Skipped Beats
- ☐ Rheumatic fever
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Persistant swelling in legs and/or feet
- ☐ Lung Problems
- ☐ Shortness of Breath, Cough, Wheeze
- ☐ Asthma
- ☐ Home Oxygen
- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA)/Mini-stroke
- ☐ Migraines/Headaches
- ☐ Blackouts/Fainting spells in last year
- ☐ Seizures
- ☐ Recent Memory Loss
- ☐ Disease of Nervous System (i.e. MS)
- ☐ Parkinson's Disease/ Tremors
- ☐ Muscle Disease
- ☐ Joint/Bone Problems (i.e. Arthritis)
- ☐ Chronic Pain
- ☐ Gout
- ☐ Frequent Heart Burn/Acid Reflux
- ☐ Ulcers
- ☐ Open Wounds
- ☐ Skin/Rashes
- ☐ Hepatitis/Jaundice/Liver Disease
- ☐ Bowel Disease (i.e. Crohn's Colitis)
- ☐ Kidney/Bladder Problems
- ☐ Hemodialysis
  Date of Next Treatment: _____ (DD/MMM/YYYY)
- ☐ Peritoneal Dialysis
  Date of Next Treatment: _____ (DD/MMM/YYYY)
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Anemia/Low Iron
- ☐ Blood Transfusion
  Date: _____ (DD/MMM/YYYY)
- ☐ Bleeding Disorders
- ☐ Sickle Cell Disease
- ☐ Blood Clots (legs, lungs, pelvis)
- ☐ Family History of Blood Clots
- ☐ Glaucoma
- ☐ Thyroid problems
- ☐ Mental Health Issues
- ☐ Dementia
- ☐ Depression
- ☐ Anxiety/Panic Attacks
- ☐ Malignant Hyperthermia
- ☐ Pseudocholinesterase Deficiency
- ☐ Implanted Electronic Devices (i.e. pacemaker, internal defibrillator,interna pain stimulator)
  Date of Last Visit: _____ (DD/MMM/YYYY)
- ☐ Other

Hospital Use Only

Interview Information

_____

☐ Known OSA (PAC referral required)

☐ High Clinical Suspicion (PAC referral required)

☐ Low Clinical Suspicion

Patient Name: _____ **PHIN:** _____

Comments: _____

_____

Are there health problems that run in your family?
Explain: _____

Have you ever had an anesthetic? . . . . . ☐ No ☐ Yes
Have you ever had a problem with the anesthetic? . . . . . ☐ No ☐ Yes
Explain: _____
Has anyone in your family ever had a problem with an anesthetic? . . . . . ☐ No ☐ Yes
Explain: _____

_____

20. List any Operations you have had:

Operation	Date (DD/MMM/YYYY)	Hospital

The last time that you had surgery, did you experience confusion, hallucination or behaviour that was unusual for you? . . . . . ☐ No ☐ Yes

21. Have you been admitted to hospital for any reason other than for surgery:

Reason	Date (DD/MMM/YYYY)	Hospital

The last time that you were hospitalized, did you experience confusion, hallucination or behaviour that was unusual for you?. . . . . ☐ No ☐ Yes

22. List any special tests you have had:
☐ Stress Test ☐ Ultrasound ☐ Angiogram ☐ Other

Test	Date (DD/MMM/YYYY)	Hospital

23. Transfusion History:
a) Do you have a rare blood type or been told that you have antibodies? . . . . ☐ No ☐ Yes
b) Do you object to blood and blood product transfusion for any reason? . . . . ☐ No ☐ Yes
c) Have you ever received blood or blood products? . . . . . ☐ No ☐ Yes
d) Did you have any problems? . . . . . ☐ No ☐ Yes

24. Do you smoke? . . . . . ☐ No ☐ Yes Do you Vaporize? . . . . . ☐ No ☐ Yes
How many per day?_____ Number of years smoked/vaporized?_____
When did you quit _____

25. Do you drink beer/wine/liquor?B . . . . . ☐ No ☐ Yes
How much? _____ How often? _____

26. Do you use recreational drugs? . . . . . ☐ No ☐ Yes
Type _____ How often? _____

Hospital Use Only

Interview Information

Mini-Cog Score (if available):
_____ ☐ Not Available

B **For patients greater than 65 years of age, flag at risk for delirium if:**
- ☐ **greater than 80 years of age**
- ☐ **benzodiazipines and/or alcohol greater than 3 x/week**
- ☐ **glasses and/or hearing aids**
- ☐ **Mini Mental Status Exam less than 24 or previous delirium**
- ☐ **assistance with any activities of daily living**

Delirium Risk Flags:
_____ /5

B **If 2 (two) or more flags are present, implement facility protocol.**

☐ N/A patient less than 65 years of age

Patient Name: _____ **PHIN:** _____

27. Do you have: ☐ Capped or Loose Teeth
☐ Dentures/Removable Teeth or Bridge Work ☐ Upper ☐ Lower
☐ Contact Lenses ☐ Hearing Aid B ☐ Right ☐ Left
☐ Eyeglasses B ☐ Body Piercings _____
Prosthesis specify _____

28. Nutrition Status: ☐ Regular Diet
a) Special diet? . . . . . ☐ No ☐ Yes
Type of diet _____
Describe eating pattern: _____
b) Difficulty eating or swallowing? . . . . . ☐ No ☐ Yes
c) Weight pattern? ☐ Stable ☐ Gain ☐ Loss Amount:_____ Time period:_____
☐ Nausea ☐ Vomiting ☐ Choking ☐ Indigestion ☐ Reflux ☐ Anorexia

29. Elimination Status: ☐ Regular ☐ Ostomy ☐ No Concerns
a) Urinary pattern? ☐ Urgency ☐ Incontinent ☐ Frequency ☐ Get up During the Night
Describe urinary pattern: _____
b) Bowel pattern? ☐ Diarrhea ☐ Constipation ☐ Incontinent
Describe bowel pattern: _____
c) Other? . . . . . ☐ No ☐ Yes
Describe: _____

30. Functional Status: ☐ No Concerns
a) Any changes in activities of daily living: . . . . . ☐ No ☐ Yes
Explain: _____

For the Day Surgery Population, ***if one or more of the risk for falls questions [30(b)(c) or (d)] is checked yes, initiate facility falls prevention screening tool***

b) Falls within 12 months: . . . . . ☐ No ☐ Yes
c) Do you require assistance with toileting, bathing, dressing, walking, feeding: . . . . . ☐ No ☐ Yes B
Explain: _____
d) Do you use any of these: ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair
☐ Scooter ☐ Mechanical Lifts ☐ Bathroom Assists
Explain: _____

e) Any changes in sleep pattern: . . . . . ☐ No ☐ Yes
Explain: _____
f) Do you have any pain: . . . . . ☐ No ☐ Yes
Explain: _____

31. What are your living arrangements? ☐ No Concerns
a) Lives: ☐ Alone ☐ Spouse/partner ☐ Child(ren) ☐ Pets ☐ Other _____
b) Residence: ☐ Apartment ☐ House ☐ Group Home ☐ Personal Care Home
☐ Supportive Housing ☐ Assisted Living
☐ Other Explain: _____
c) Must use stairs: ☐ No ☐ Yes Number:_____
Is there a railing? ☐ No ☐ Yes

32. Are you using any community services right now? ☐ No Services
☐ Home Care ☐ Physiotherapy ☐ Occupational Therapy
☐ Dietitian ☐ Day Hospital ☐ Lifeline®
☐ Handi-transit ☐ Other
☐ Treaty Number_____ ☐ Band Name: _____
☐ Social Assistance Case Worker Name: _____
Phone# _____ Case # _____

33. Who completed this form? ☐ Patient
☐ Other Name/Relationship: _____

Hospital Use Only

Interview Information

☐ Consults Initiated

_____

☐ Facility Falls Prevention Screening Tool Initiated

_____

Screened by RN: _____

Date (DD/MMM/YYYY)/Time (24 HOUR)

_____

Assessed by RN: _____

Date (DD/MMM/YYYY)/Time (24 HOUR)

_____

Thank you for taking the time to complete this questionnaire.

Patient Questionnaire is valid for 6 months, provided there has been no significant change in the patient's condition.

GRACE HOSPITAL

PRE-ADMISSION FORM

Please complete and return to your Surgeon's office as soon as possible.

If you must cancel your surgery, please CONTACT YOUR DOCTOR'S OFFICE immediately so the time can be given to another patient.

SURNAME	GIVEN NAME	GENDER	TITLE	MAIDEN/PREVIOUS NAME
		☐ Female ☐ Male	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	
ADDRESS		CITY	PROVINCE	POSTAL CODE

TELEPHONE NUMBERS: HOME	BUSINESS	MESSAGE	DATE OF BIRTH: DAY	MONTH	YEAR	AGE
( )	( )	( )				

ALLERGIES (MEDICATIONS AND FOOD)	DO YOU WISH TO STATE A RELIGION?

REGISTRANT'S SURNAME & GIVEN NAME (Name on front of MHSC card)	EMPLOYER OF REGISTRANT

HAVE YOU BEEN A PATIENT IN THIS HOSPITAL BEFORE?	PHIN:	FAMILY DOCTOR
☐ YES ☐ NO		

NAME OF SPOUSE, NEAREST RELATIVE, OR FRIEND	RELATIONSHIP

ADDRESS AND TELEPHONE NUMBER

IF YOU ARE NOT REGISTERED WITH MHSC, ARE YOU PLANNING TO STAY:	DATE OF ARRIVAL IN MANITOBA
☐ TEMPORARY IN MANITOBA OR ☐ PERMANENT IN MANITOBA	
OTHER PROVINCIAL PLAN NO. & EXPIRY DATE (if applicable)	PREVIOUS ADDRESS IN FULL

MHSC NUMBER	**Your MHSC # covers STANDARD accommodation only.**	ACCOMMODATION REQUESTED
		☐ Standard ☐ Semi-Private ☐ Private

PRIVATE INSURANCE	CONTRACT/POLICY NO.	GROUP NO.	POLICY HOLDER
☐ Blue Cross ☐ Other _____			

WCB CLAIM NO. (if applicable)	PATIENT'S EMPLOYER

I hereby request a private/semi-private room when available and agree to pay the additional charges either personally or with proceeds from an insurance assignment, or both, to Grace Hospital. I further authorize Grace Hospital to release such information as may be necessary for the completion of my hospitalization claim.

DATE	SIGNATURE OF APPLICANT

Patient's Instructions Before Surgery

FORT WHYTE
ORTHOPEDICS
RESTORING *motion* FOR LIFE

FORT WHYTE ORTHOPEDICS
304-1020 LORIMER BLVD
WINNIPEG, MB R3P 1C7
PHONE: 204-560-2272
FAX: 204-815-5755
EMAIL: info@fortwhyteorthopedics.com

DEADLINE FOR ALL PAPERWORK: _____

Patient's Name:

Surgery Date: _____ Admission Time: _____

Surgery Site:

☐ **GRACE HOSPITAL**
300 BOOTH DR
WINNIPEG, MB

☐ **PANAM CLINIC, SURGERY DEPARTMENT**
75 POSEIDON BAY
WINNIPEG, MB

INSTRUCTIONS

Please have the following documents and indicated preoperative test results completed by the deadline. Delays in receiving results will delay your surgery.

(1) The office will contact you for a surgery date, once you receive that date, you may start preparing your preoperative paperwork. Note: patients on the Cancellation List can start as soon as they receive their package.

(2) Schedule an appointment with your family doctor or primary care provider to complete a History and Physical (H&P). Discuss with them any questions you may have about your care. Have them send the H&P form (enclosed) and any relevant test results to our office by fax as soon as completed.

(3) Complete the forms in this package indicated below. Return them to our office by fax or email.

- ❑ *Patient Pre-Admission* form
- ❑ *WRHA Surgery Program – Preoperative Assessment Patient Questionnaire*
- ❑ Signed surgery consent form

(4) **If necessary**, after your forms are sent to the surgery site, a nurse from the Preoperative Assessment Clinic (PAC) may call you to schedule a PAC appointment. If so, please attend this appointment and **bring your medications in their bottles.** Do not be concerned if you do not receive a call from PAC.

FORT WHYTE ORTHOPEDICS
304-1020 LORIMER BLVD
WINNIPEG, MB R3P 1C7
PHONE: 204-560-2272
FAX: 204-815-5755
EMAIL: info@fortwhyteorthopedics.com

BEFORE SURGERY

- **DO NOT** consume any food, orange juice, or sports/carbonated beverages after midnight to prevent vomiting during or after surgery. Clear fluids are allowed up to 2 hours before reporting to admitting/registration (e.g. water, apple juice, cranberry juice, black coffee/tea with no milk or sugar added).
- Unless otherwise advised by the Pre-Admission Clinic, **you must NOT** eat anything (including gum, candy and chewing tobacco)
- If you take medications, you will receive instructions from the Preoperative Assessment Clinic (PAC) prior to surgery on which medications to continue and which to stop.
- Bathe or shower the **night before surgery** and the **morning of surgery**. **DO NOT** wear nail polish, make-up, or use hairspray, lotions, deodorant, perfumes or aftershaves.
- **DO NOT** shave the area where your surgical incision will be for at least one (1) week prior to your surgery.
- Patients are **not permitted** to wear jewellery (including body piercings) in the Operating Room. If you have jewelry that requires removal by a jeweller (e.g. rings that do not slide off), please arrange to have these removed prior to your admission. **Remaining jewellery will either have to be cut off at the hospital or the surgery will need to be cancelled.**
- If you are sick (e.g. sore throat, fever, cough symptoms) within 1 week before your surgery, contact your surgeon's office immediately.
- Bring a robe and slippers for your own use as well as any cases, labelled with your name, for glasses, contact lenses, hearing aids or dentures.
- If you own a CPAP or BIPAP machine (even if you do not use it), please bring it to the hospital the day of your surgery.

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AFTER SURGERY

- If you are scheduled as a ***Day Surgery Patient****:*
- You will be discharged from the hospital approximately 1 to 3 hours after surgery. Please make arrangements for a responsible adult to drive you home. You will be asked to provide their name and phone number when you arrive at Patient Registration. A responsible adult must stay with you overnight if you have received an anesthetic
- If you had a general aesthetic, intravenous sedation or are taking prescription pain medication, you should wait 24 hours before driving, making legal decisions or operating any appliance or equipment that may result in a burn or injury.
- If you are from out-of-town and are staying in Winnipeg the night before surgery, please call the Surgical Centre with the number in Winnipeg where you can be reached
- If you live more than one hour drive out of the city plan to stay in the city overnight
- If you are scheduled for ***Hip/Knee Joint Replacement:***
- You will be staying at the hospital for approximately three (3) days. Do not be alarmed if you are discharged sooner
- Swelling and bruising is perfectly normal for up to 6 months post-surgery, if any unusual symptoms arise contact your surgeon's office immediately or report to the nearest urgent care/emergency department
- Once you are discharged from the hospital call your surgeon’s office for an appointment in 3 weeks for staple removal unless told otherwise by your surgeon