WEATHERFORD HOSPITAL AUTHORITY
DBA
WEATHERFORD REGIONAL HOSPITAL
3701 E. MAIN WEATHERFORD, OK 73096

Ambulatory Surgical Check List

Appropriate Line to be Intialed *

Date _____ Admit Time: _____

1. Surgical Procedure _____
2. Surgical consent signed and witnessed _____
3. Lab results on chart: CBC _____ DONE _____ ON CHART _____
4. UA _____ DONE _____ ON CHART _____
5. BLOOD SUGAR _____ DONE _____ ON CHART _____
6. Chest X-Ray on Chart: _____
7. EKG on Chart: _____
8. History & Physical on Chart _____
9. Allergies: _____
10. Allergy & I.D. bands on and correct: _____
11. Pre-op TPR & BP charted: _____
12. NPO since: _____ Voided at _____
13. Dentures removed _____ yes _____ no
14. Contact lenses or glasses removed: _____
15. Jewelery removed or secured: _____
16. Ready for surgery: Time _____
17. Siderails up: _____
18. Pre-op done or No pre-op ordered _____
19. To OR: Time _____

PRE-OPERATIVE TEACHING

Date & Time	Skin Prep	Dressing	Diet	Routine Post-op Activity	Pain Medication	I.V. Fluids

Medication & Strength	Route	Date	Time	Int

Teaching Comments _____

Int.	Nurse's Signature Signature	Title

* Initials signify teaching done (There are to be no blank lines on the checklist. Use N/A if not applicable to the patient, or "none ordered" if no pre-operative medication).

_____
Nurse's Signature

_____
Surgery Nurse's Signature

4/94

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Ambulatory Surgery
Nursing Assessment Form

Admit:
Date: _____ Time: _____

SURGICAL PROCEDURE _____

Admit per: Amb. W/C Carrier

For: Amb. Surgery Overnight

HAVE YOU HAD:

Heart Trouble	Yes	No
High Blood Pressure	Yes	No
Lung Disease	Yes	No
Epilepsy or Seizures	Yes	No
Jaundice	Yes	No
Hepatitis or Mononucleosis	Yes	No
Back Trouble	Yes	No
False or Loose Teeth	Yes	No
Dental Caps or Bridges	Yes	No
Glaucoma	Yes	No
Abnormal Bleeding Tendencies	Yes	No
Anticoagulant Therapy	Yes	No
Blood Disease (Anemia, ect.)	Yes	No
Kidney Disease	Yes	No
Fracture of Facial Bones	Yes	No
Fracture of Neck or Back	Yes	No
Muscle Weakness	Yes	No
Paralysis	Yes	No
Blood Transfusion	Yes	No
Diabetes	Yes	No
Arthritis	Yes	No
Trouble Hearing	Yes	No

Other Medical Illnesses (please list)

_____

_____

Do You:

Wear Contact lenses	Yes	No
Smoke (pkg/day)	Yes	No
Use Alcoholic Beverages	Yes	No
Wear Glasses	Yes	No

LIST PREVIOUS SURGERIES (type & date): _____

_____

_____

_____

_____

_____

LIST MEDICATIONS YOU ARE PRESENTLY TAKING

AND LAST DOSE: _____

_____

_____

_____

_____

_____

_____

_____

LIST ALLERGIES (drug, other): _____

_____

_____

AGE: _____ HEIGHT: _____ WEIGHT: _____

B/P _____ P _____ R _____ T _____

Instructions/Comments: _____

_____

_____

_____

_____

_____ _____ _____

Signature Admitting RN Nurse's Signature Date

IMMEDIATE POST-OPERATIVE FLOW SHEET

	RETURN FROM SURG.			DISCHARGE	
TIME					
LEVEL OF CONSCIOUSNESS	Awake Alert Oriented Dis-oriented Drowsy		Awake Alert Oriented Dis-oriented Drowsy		Awake Alert Oriented Dis-oriented Drowsy
TIME					
B.P.					
PULSE					
RESP. RATE					
I.V. SOLUTION AND RATE					
IV SITE * Concern	Site * Clear Discontinued In Surgery		Site * Clear In Surgery		Site * Clear In Surgery
DRESSING	Dry None Intact Reinforced Changed		Dry None Intact Reinforced Changed		Dry None Intact Reinforced Changed
POST-OP DISCOMFORT	Denied Mild Concern *		Denied Mild Concern *		Denied Mild Concern *
TREATMENT	Ice Pack				
DIET					

Nurse's Signature

* See Nurses Notes

MEDICATION SINGLE DOSES: POST-OPERATIVE

Medication & Strength:	Route	Date	Time	Int.

DISCHARGE SUMMARY

Discharge Plan: _____ Time: _____

Person to accompany pt. home: _____

DEPARTED PER:

_____Ambulatory
_____Wheelchar
_____Carrier
_____Other

TRANSPORTATION:

_____ Private Vehicle
_____ Ambulance
_____ Other

DESTINATION:

_____Home
_____Nursing Home
_____Admitted
_____Other

PT. CONDITION:

_____Alert
_____Without Complaint
_____Complaint *

TAKEN WITH PATIENT AT DISCHARGE:

_____Written, Signed Home Instructions
_____Eye Kit _____ Other: _____
_____All personal possessions

ALDRETE SCORE	ACTIVITY 2-able to move 4 ext. 1-able to move 2 ext. 0-not able to control ext.	RESPIRATION 2-able to breathe deeply 1-limited resp. effort 0-no spontanious resp	CIRCULATION 2-BP +/- 20% base 1-BP +/-20-50% base 0-BP +/- 51% or> base	CONSCIOUSNESS 2-full alertness 1-arousable 0-no reponse	COLOR 2-normal skin color 1-pale/dusky/blotchy 0-cyanosis	TOTAL
Pre-Operatively Time:						
Post-Operatively Time:						

TIME:	PROGRESS NOTE

SHORT STAY RECORD

Patient Name	Attending Physician	Date	Hospital Number

Admitting Diagnosis and Brief History: _____

Allergies: _____

Medications: _____

Significant Past Medical/Surgical/Anesthesia History: _____

	Not Evaluated	Normal	Abnormal Findings
Heent			
Cardiovascular			
Pulmonary			
Abdomen			
GU System			
Neurologic			
Pelvic/Rectal			

PROGRESS RECORD

Physician Signature _____ Date _____

Last Name	First Name	Middle Name	Room No.	Bed	Hospital No.