SUMMIT MEDICAL ASSOCIATES, P.C.

EVENTS IN PATIENT HOSPITAL TRANSFER

EVENTS

Time	To Be Completed by RR Staff as events occur
_____	The Nursing Director was notified by _____ .
_____	The ND not notified because _____ . The person fulfilling the duties of the ND in this transfer _____ .
_____	_____ (ND/Designated Staff Person) notified the ambulance service and specified to them that it is _____ (An Emergency/Non Emergency) transport. The ETA is projected to be _____ .
_____	The ND notified _____ (Director).
_____	The ND posted staff member, _____ , at the ambulance entrance to direct ambulance staff. Patient was accompanied to the hospital by staff member, _____ . Time of actual departure was _____ .
_____	The _____ (Physician/ND) notified Northside Hospital (851-8000) of the impending patients' arrival, status and orders.
_____	_____ notified family, friend of the decision to transfer patient.
_____	_____ prepared the medical records to be transferred with patient (administrative staff person).
_____	The ND sent all patient personal items _____ (with the patient/home with the family).
_____	_____ (ND) gave copied medical records, transfer sheets and report to ambulance personnel.

_____ _____

(Party Responsible For Filling Out This Form) Date

SMA022

SUMMIT MEDICAL CENTER, P.C.
TRANSFER RECORD

DATE: _____

PATIENT NAME _____ BIRTHDATE _____

ADMISSION DATE _____ DIET _____

DIAGNOSIS _____ REASON FOR TRANSFER _____

ALLERGIES _____

ATTENDING RELATIVE _____ DISABILITIES _____

NEAREST REALTIVE _____ RELATIONSHIP _____

PHONE _____ ADDRESS _____

TRANSFER TO _____ UNIT _____ PHONE _____

MODE OF TRANSPORTATION _____

MEDICATIONS	TIMES	LAST DOSE	TREATMENTS	TIMES

IV FLUIDS	RATES	LEFT TO COUNT

PERTINENT PAST HISTORY _____

POST—OPERATIVE EVALUATION _____

CARDIAC RHYTHM _____

ACTIVITY LEVEL _____

O_2 _____

FOLEY _____

LEVEL OF CONSCIOUSNESS: ____ ALERT ____ ORIENTED ____ DROWSY ____ LETHARGIC

____ DISORIENTED ____ SEMICOMATOSE ____ COMATOSE ____ CALM ____ ANXIOUS ____ AGITATED

____ DEPRESSED ____ FEARFUL ____ UNCOOPERATIVE ____ OTHER _____

COURSE OF SURGERY AND COMPLICATIONS: _____

TRANSFER EVALUATION _____

CONDITION UPON TRANSFER: ____ GOOD ____ FAIR ____ SERIOUS ____ CRITICAL

VITAL SIGNS PRIOR TO TRANSFER: B/P ____ PULSE ____ RESP ____ TEMP ____

REPORT CALLED: ____ YES ____ NO RECEIVED BY _____

NURSE'S SIGNATURE _____ DATE _____

SUMMIT MEDICAL ASSOCIATES, P.C.

CONFIDENTIAL PATIENT INFORMATION

(Please Print) DOB: _____ SS# _____

NAME: _____ DATE: _____ TIME: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY

_____
STATE ZIP COUNTY

PHONE: _____
HOME WORK CELL

INSIDE CITY LIMITS: YES / NO HAVE YOU BEEN TO THIS CLINIC BEFORE? YES / NO IF YES WHEN? _____

AGE: _____ NAME OF OB/GYN DOCTOR: _____ LAST MENSTRAL PERIOD _____

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS: _____ SEX: _____

NEAREST RELATIVE: _____ HOW DID YOU HEAR ABOUT US? _____

REGARDLESS OF THE TYPE OF ANESTHESIA YOU RECEIVE WITH YOUR PROCEDURE, YOU WILL NEED A RESPONSIBLE ADULT TO ACCOMPANY YOU ON DISCHARGE. Even with minor procedures, there is always the possibility that you could experience an anesthesia side effect after leaving the office. For this reason you MUST HAVE A RESPONSIBLE ADULT TO ACCOMPANY YOU UPON DISCHARGE OR WE CAN NOT DO YOUR PROCEDURE TODAY. Your total stay time at the office will take about 5 - 8 hours. In rare instances, it could be longer. The adult with you is free to leave after checking you in and should return at least one hour prior to the time you will be ready for discharge.

In the rare event that the accompanying adult leaves the office and does not return, the patient will be required to remain under observation in the office for at least two (2) times the normal post-procedure period. At that time, the physician will be consulted with regards to the discharge of the patient. Upon his disposition, the patient may be sent home in a taxi with the patient being responsible for the charges incurred in this transport.

I have read the above statement. I have arranged for a responsible adult to accompany me from the office after discharge.

Patient signature: _____ **Date:** _____

I have read the above statement. I have agreed to be the responsible adult who accompanies the patient from the facility after discharge.

Responsible Adult's Signature: _____ **Date:** _____

PATIENT- NOTHING BY MOUTH STATEMENT - Complete this statement on the day of your surgery.

I have not had anything to eat or drink including water, gum, or mouth mints since midnight last night. If I did eat or drink, what did you eat or drink? _____ **Date:** _____ **Time:** _____

Patient's Signature: _____

SUMMIT MEDICAL ASSOCIATES, P.C.
MEDICAL HISTORY & ANESTHESIA EVALUATION

Name:_____ Age:_____ Ht:_____ Wt:_____ Date:_____

ALLERGIES AND REACTIONS: ☐ Yes ☐ No If yes, list with reactions:_____

DRUG HISTORY:

Medication/drugs taken within the last month, including psychotrophic, diuretics, B/P medication, cardiac, steroids, diet pills, etc.

☐ Yes ☐ No If yes, list:_____

Recreational/street drugs taken within the last month, including marijuana, cocaine, etc.

☐ Yes ☐ No If yes, list:_____

DISEASE HISTORY:

Do you have any infectious diseases now?_____

Do you have or have you had any of the following?

Yes	No	Vascular:
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Heart disease or attack
☐	☐	Stroke or TIA
☐	☐	Mitral Valve Prolapse
☐	☐	Rheumatic Fever
☐	☐	Heart Murmur
☐	☐	Bleeding or clotting problems
☐	☐	Anemia
☐	☐	Sickle-cell
☐	☐	Blood transfusion
☐	☐	Varicose Veins
☐	☐	Rh negative blood

Yes	No	Respiratory:
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Emphysema
☐	☐	TB
☐	☐	Colds, Flu
☐	☐	Smoker
Yes	**No**	**Systemic:**
☐	☐	Drug/Alcohol Dependence
☐	☐	Emotional Problems
☐	☐	Psychiatric Illness
☐	☐	Unusual Muscle Weakness in arms or legs
☐	☐	Lupus
☐	☐	Liver problem, Hepatitis, Cirrhosis
☐	☐	Diabetes
☐	☐	Seeing Psychiatrist (now/past)

☐	☐	Epilepsy
☐	☐	Thyroid trouble
☐	☐	Bladder or kidney trouble
☐	☐	Glaucoma
☐	☐	Ulcers or stomach problem
☐	☐	Cancer
☐	☐	Breast Lump or Tumor
☐	☐	Hypoglycemia
☐	☐	Latex Allergy
Yes	**No**	**Other:**
☐	☐	Gonorrhea
☐	☐	Syphilis
☐	☐	Herpes
☐	☐	HIV-AIDS
☐	☐	Chlamydia
☐	☐	Genital Warts

☐ ☐ Other than listed:_____

ANESTHESIA EVALUATION:

Yes No Type of anesthesia requested: General_____ Local_____ MAC (Local with sedation)_____

☐ ☐ 1. List any serious illnesses (present or past):_____

☐ ☐ 2. List any previous surgeries:_____

☐ ☐ 3. Have you or any relatives had any problem with a prior anesthetic?
☐ Breathing Difficulty ☐ High Fever ☐ High or Low B/P ☐ Prolonged Paralysis ☐ Jaundice ☐ Nausea

☐ ☐ 4. Are you wearing contact lenses now? (Day of Surgery) ☐ Yes ☐ No

☐ ☐ 5. Do you have any ☐ False ☐ Capped ☐ Loose or ☐ Chipped Teeth? Location:_____

☐ ☐ 6. Do you smoke? How much?_____

☐ ☐ 7. Alcohol? Drugs? How much?_____

☐ ☐ 8. Do you have any physical restrictions or limitations? Back or neck problems or injuries? ☐ Yes ☐ No
Explanation_____

☐ ☐ 9. Do you have asthma, wheezing or cough?_____

☐ ☐ 10. Do you have shortness of breath or chest pain on exertion?_____

☐ ☐ 11. Do you have any objection to blood transfusion should there be a life threatening emergency?_____

FAMILY MEDICAL HISTORY: Has anyone in your family ever had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Complication with anesthesia	☐	☐	Heart or kidney disease	☐	☐	Cancer
☐	☐	Genetic conditions	☐	☐	Diabetes	☐	☐	Pregnancy problems
☐	☐	High blood pressure	☐	☐	Tuberculosis	☐	☐	Emotional problems

Comments:_____

OBSTETRICAL/GYNECOLOGICAL HISTORY:

Yes No ☐ ☐ Ovarian Cysts Yes No ☐ ☐ Fibroid Uterus Yes No ☐ ☐ PID/(Infection in tubes)

Results of Last Pregnancy
☐ Full Term ☐ Stillbirth (20-36 wks) ☐ Spontaneous Termination/ Induced Termination
☐ Premature ☐ Full Term (>36 wks)

Date of:
_____ Last delivery
_____ Last abortion/miscarriage
_____ Last PAP smear
_____ Last pelvic exam

_____ Date of recent Pregnancy test
_____ First day of last NORMAL period

Please list the number of:
_____ Full term deliveries
_____ Premature deliveries
_____ Abortions, wks. gest._____
_____ Miscarriages, wks. gest._____
_____ Vaginal delivery

_____ Cesarean section
_____ Ectopic pregnancies, wks. gest. _____
_____ Date of last fetal death
_____ Number of living children
_____ Date of last live birth

Did you have any problems with previous pregnancies and/or pregnancy terminations?_____
What facility:_____
Birth Control Method at Time of Conception:_____

61305

Signed:_____