Doctors Hospital at Deer Creek
815 South 10th Street
Leesville, LA 71446
Office (337) 392 – 5088 or (337) 392-4977
Fax (337) 392 - 4984

NOTE: THE DOCTORS OFFICE SHOULD SET YOU UP A PRE-REGISTRATION APPOINTMENT MONDAY - FRIDAY 7:30AM TIL 4:30PM. THIS APPOINTMENT IS TO BE PRIOR TO THE SURGERY DATE, IF NOT PLEASE CALL 337-392-4977.

TO BRING:

PAGES 2 & 3

PICTURE ID

INSURANCE CARD

LIST OF MEDICINE

THANK-YOU

DOCTORS HOSPITAL AT DEER CREEK **PATIENT REGISTRATION FORM**

Patient Last Name ______________________ First ______________________ MI ______

Address______________________ City______________ State______ Zip__________

Home Phone (____) ______________ Cell Phone(____) ______________

DOB _____/_____/________ SSN ________-______-________ M/F ______ Marital Status (M/S/D/W) ______

Religion: ______________ Race ____________ Employment (F/P/R/U) _______ Date of Retirement____________

Employer______________________ Address______________________

Occupation______________ Work Phone(____) ______________

Emergency Phone(____) ______________ Name & Relationship ______________

<u>If pt is under 18, please complete this section:</u>

Responsible party: ______________________ M/F______ DOB____/____/________
Last First MI

Relationship to patient______________________ Responsible party SSN ______-______-________

Employer______________________ Address______________________

Occupation______________ Work Phone(____) ______________

	Primary Insurance	Secondary Insurance
Subscriber Name		
SSN		
DOB & Relation		
Employer/Occupation		

Date of Injury____/_____/_______ Location_______ Employment (Y/N)_______ Automobile(Y/N)_____ Personal(Y/N) ______

- Additional procedures may be necessary as above procedure(s) is/are being performed.
Have you been informed of this and possible related additional charges? _______Yes ______No Initials_________
- Previous Admit to Doctors Hospital at Deer Creek? (Y/N) _______

PATIENT'S SIGNATURE______________________ **DATE** ______________

DOCTORS HOSPITAL AT DEER CREEK　　　　PRE-ANESTHESIA ASSESSMENT and PLAN OF CARE

THIS FORM TO BE COMPLETED BY THE PATIENT PRIOR TO PRE-REGISTRATION.

PRINT PATIENT NAME: ______________________________ **AGE:** ________ **WT:** ________ **HT:** ________

DRUG ALLERGIES, FOOD ALLERGIES
(i.e.: Eggs/Wine/Cheese)

MEDICATIONS PRESENTLY TAKING:
Beta Blocker prior to surgery: ☐Yes ☐No
Date & Time:_________/_________

PREVIOUS SURGERIES:

PREVIOUS ANESTHESIA:
Any problems? i.e.: increased temp during surgery ( ) Yes ( ) No
History of anesthesia problems? ( ) Yes ( ) No
Family History of problems? ( ) Yes ( ) No
Date and Location of last anesthetic: ____________________

Comments:

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?
If YES, please explain under comments using corresponding number

NO / YES
___/___ 1. Jaw or facial problems
___/___ 2. Asthma, Emphysema, Bronchitis
___/___ 3. Do you smoke? _________ Packs/day
___/___ 4. High Blood Pressure
___/___ 5. Heart Disease, chest pain, or shortness of breath
___/___ 6. Hepatitis or Yellow Jaundice
___/___ 7. Alcohol or Drug Abuse
___/___ 8. Kidney Disease
___/___ 9. Stroke
___/___ 10.Diabetes Mellitus
___/___ 11. Anemia, Sickle Cell, or free bleeding
___/___ 12. Epilepsy or Seizures
___/___ 13. Are you Pregnant? LMP ____________
___/___ 14. Any limited neck motion
___/___ 15. Any pain, numbness/weakness in your arms/legs
___/___ 16. Taken any steroids within the last six months
___/___ 17. Glaucoma, eye disorders or contact lenses
___/___ 18. Diet programs or diet medications
___/___ 19. Herbal or over the counter medications
___/___ 20. Hiatal Hernia, Gastric Reflux or Gastrointestinal Problem
___/___ 21. Gout or Arthritis
___/___ 22. Any religious contraindications to Blood Transfusions
___/___ 23. Dentures, Bridgework, capped or Loose teeth
___/___ 24. Motion sickness or inner ear problems
___/___ 25. Infectious Diagnosis
___/___ 26. Blood Thinners ( ) Coumadin ( ) Plavix ( ) ASA
Last Dose taken ______________

____
Patient Signature

******PLEASE DO NOT FILL IN BELOW THIS LINE******

ANESTHESIA PLAN OF CARE (To be filled out by anesthesia provider)
TYPE OF ANESTHESIA PLANNED:

( ) GENERAL　　MALLAMPATTIE CLASS: I, II, III, IV　　*If DM, Accucheck (DOS) ____________
( ) REGIONAL　　ASA CLASS: I, II, III, IV, V
( ) LOCAL
( ) MONITORED ANESTHESIA CARE　　DIAGNOSTIC RESULTS REVIEWED ( ) YES ( ) NO
( ) CONSCIOUS SEDATION　　NPO TIME: ______________ DATE: ______________

Based on the information above and relevant diagnostic studies, I determine that the patient is an appropriate candidate for the anesthesia planned, I further reviewed anesthesia, its risks, and options have been explained to the patient/ or family to which he/she agree documented on the operative consent.

ANESTHESIA PROVIDER SIGNATURE: ____________________ DATE: ______________ TIME: __________

POST-OP EVALUATION

Complications: ____Yes ____ No
Status: ______________________________

MD/CRNA/NURSE SIGNATURE: ____________________ DATE: ______________ TIME: __________

Revised: 06/29/2010

DOCTORS HOSPITAL AT DEER CREEK PRE-OP INFORMATION

BEFORE PRE-REGISTRATION:

MINORS: Consent for anyone under age 18 must be given by their parent or legal guardian. A copy of the legal guardianship documents must be provided. **If your child is scheduled for surgery, the child must come to the Pre-op appointment.** A written excuse can be obtained for school officials.

ADVANCED DIRECTIVE OR LIVING WILLS: If you have a living will or advanced directive you will need to provide us a copy of the document. If you need an advanced directive, please request one from the admitting personnel at the time of registration.

HEALTH CHANGES: If you experience any kind of health care changes between your visit to your Physician and the day of your procedure, notify the Physician. Report any changes such as elevated temperature, and cough or cold symptoms to your physician.

DIAGNOSTIC STUDIES: Your physician may order pre-procedure diagnostic testing to be done during your pre-registration process.

PRE-REGISTRATION DAY:

During the Pre-registration process you will be interviewed by a Registration Clerk and Anesthesia Provider.

PLEASE BRING THE FOLLOWING:

1. **MEDICATIONS CURRENTLY TAKING**
2. **INSURANCE CARDS**
3. **DRIVER'S LICENSE OR CURRENT ID**
4. **PATIENT REGISTRATION FORM (PAGE 2)**
5. **PRE-ANESTHESIA ASSESSMENT AND PLAN OF CARE (PAGE 3)**

DAY BEFORE YOUR PROCEDURE:

- **NO TOBACCO** should be smoked or chewed the day before the procedure or the day of the procedure.
- **NO ALCOHOLIC BEVERAGES** are to be consumed the day before the procedure or the day of the procedure.
- **ACTIVE DUTY SOLDIERS:** No physical training or overnight procedures should be performed 24 hours prior to the morning of your procedure due to the increased risk of dehydration and/or heat injuries as a result of being NPO (nothing to eat or drink by mouth).

DAY OF YOUR PROCEDURE:

- **DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT: NO COFFEE OR WATER!** Undigested food in the stomach can cause complications and your procedure will be cancelled or delayed if you forget to follow this instruction. Provided is a guideline for you to follow:

  EXCEPTIONS:

  - If you take any blood pressure, reflux or asthma medications you can take it with a sip of water.
  - Newborns – 6 Months **NO MILK OR SOLIDS 4 HOURS PRIOR TO SURGERY**
  - 6 Months – 36 Months **NO MILK OR SOLIDS 6 HOURS PRIOR TO SURGERY**
  - Older than 36 Months- ***NOTHING TO EAT OR DRINK AFTER MIDNIGHT***
- **BATHE OR SHOWER** and brush your teeth (making sure not to swallow any water) the morning of your procedure. This will assist you in feeling refreshed as well as minimize the chance of infection.

PATIENTS KEEP THIS PAGE FOR YOUR INFORMATION

- **CLOTHING: Only 100% cotton underwear can be worn in the operating room due to static electricity from the machines.** Wear loose fitting clothing. If you are having an arm or leg operated on, please wear clothing that will enable you to dress easily with no restrictive clothing. Example: Knee arthroscopies wear shorts or wind pants that unsnap; shoulder surgeries wear button up shirts.

- **RESPONSIBLE ADULT:** You must have a responsible adult to accompany you home. It is advisable to have someone be with you the first twenty four hours after the operation.

- **MEDICATIONS:** Unless instructed otherwise by your Physician, you may take the following medications early on the morning of surgery with a sip of water: heart, blood pressure, reflux, and asthma. Bring your regular medications or a current list with you.

- **DIABETIC PATIENTS: DO NOT TAKE** your diabetic medications the morning of your procedure.

- **IDENTIFICATION:** Please be sure to bring your ID.

- **GLASSES, DENTURES OR CONTACTS:** If you wear any of these items please bring a case or container to place them in.

- **CHILDREN:** Must be accompanied by a parent or legal guardian who is at least 18 years old. If you would want you can bring a favorite blanket, or toy for child having surgery. Please provide childcare for children not having surgery.

- **MAKEUP, JEWELRY, PERFUME, LOTIONS, POLISH AND HAIRSPRAY:** Do not wear any of these items the morning of your procedure. ALL body piercings ***must*** be removed. Do not wear hairpins, rings, necklaces or anything metal.

- **SHAVING SURGICAL AREA:** Please do not shave the surgical area unless directed to do so by your physician. This will be done in the Pre-Op or the Operating Room if needed.

AFTER YOUR PROCEDURE:

- **RECOVERY ROOM:** After your procedure, you will be moved to the Recovery Area where you will remain under close supervision by the staff until you are ready to go home. Although the length of stay postoperatively varies according to the type of procedure, anesthesia used, and your Physician's instructions, most patients are discharged between 1 to 2 hours after their procedure, unless procedure requires further hospital stay.

- **RESPONSIBLE ADULT:** The adult accompanying you will be given your discharge instructions and bring the vehicle in which you will ride home to the hospital entrance. A member of the surgical team will assist you to your automobile.

- **DISCHARGE CRITERIA:** You will be discharged from the hospital when you can walk, tolerate fluids, have minimal pain, and show no signs of complications. Some nausea and vomiting is common for the first 24 hours after general anesthesia.

- **24 HOURS AFTER DISCHARGE:** Pamper yourself the first 24 hours following your procedure. Since it is normal to feel drowsy after receiving anesthetic, we urge you to postpone these activities for 24 hours: ride a bicycle, sign important papers or operate machinery of any kind for 24 hours after you are discharged.

- **DISCHARGE INSTRUCTIONS:** Before you leave the hospital, you and your responsible adult will receive discharge instructions as ordered by your Physician regarding activity, rest, diet, medication, signs and symptoms of complications.

PATIENTS KEEP THIS PAGE FOR YOUR INFORMATION