

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:



Please Fax to: PAC Department Facility Fax # []-[]-[]-[]-[]-[]-[]-[]-[]-[] Surgeon's Office Fax # []-[]-[]-[]-[]-[]-[]-[]-[]-[]

Diagnosis _____

Proposed Procedure _____ Proposed Date [] [] [] [] [] [] [] [] [] [] [] [] [] [] [] []

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

PART B – HISTORY	No	N/A	Yes	Describe (e.g. type, quantity, frequency)								
B1. Tobacco Use	<input type="checkbox"/>		<input type="checkbox"/>	Pack years _____ Date quit [] [] [] [] [] [] [] [] [] [] [] [] [] [] [] []								
B2. Vaporizer/e-cigarette use	<input type="checkbox"/>		<input type="checkbox"/>	_____								
B3. Recreational Drugs	<input type="checkbox"/>		<input type="checkbox"/>	_____								
B4. Alcohol Consumption	<input type="checkbox"/>		<input type="checkbox"/>	_____								
B5. Previous or Current Steroid Therapy	<input type="checkbox"/>		<input type="checkbox"/>	_____								
B6. Date of Last Menses	<input type="checkbox"/>		<input type="checkbox"/>	[] [] [] [] [] [] [] [] [] [] [] [] [] [] [] []								
B7. Pregnancy Test	<input type="checkbox"/>		<input type="checkbox"/>	If done, results: _____								
B8. Medical History (please indicate stable or acute)			<input type="checkbox"/>	See attached*								
<table border="1"> <thead> <tr> <th>B9. History of Present Illness</th> </tr> </thead> <tbody> <tr> <td>_____</td> </tr> <tr> <td>_____</td> </tr> <tr> <td>_____</td> </tr> </tbody> </table>					B9. History of Present Illness	_____	_____	_____				
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<input type="checkbox"/> See attached*												

* Do not attach extensive encounter notes

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

Height _____ cm Weight _____ kg Body Mass Index (BMI) _____ Blood Pressure _____ Heart Rate _____ SpO₂ _____
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 *If possible, please address with the patient any of the following applicable items to reduce the risk of postoperative complications:*

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

Healthy Behaviours <ul style="list-style-type: none"> • Active lifestyle • Healthy diet 	<ul style="list-style-type: none"> • Reducing excessive alcohol use • Recreational drug cessation • Smoking cessation 	Chronic Diseases Management <ul style="list-style-type: none"> • Diabetes screening/Blood glucose control • COPD/Asthma • Hypercholesterolemia • Hypertension • Malnutrition • Nutritional Anemias
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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	GUIDELINE DOES NOT APPLY TO
as additional tests may be appropriate for some patients.	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⁺, Cr, TCO₂, 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: _____ _____ Examination Date: _____
SIGNATURE PRINTED NAME AND DESIGNATION 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: _____ _____ Reassessment Date: _____
SIGNATURE PRINTED NAME AND DESIGNATION D D M M M Y Y Y Y

Comments: _____