



Oakville Trafalgar  
Memorial Hospital  
3001 Hospital Gate  
Oakville, Ontario  
L6M 0L8

# Day Surgery

## Pre-Admission Clinic Package

### To the Patient:

- You will be contacted by the Pre-Admission Clinic to arrange a clinic visit.  
If you have not been contacted within 7 days of your surgery, please call:  
905-338-4497

Pre-Admission Clinic Appointment:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**YOU MUST** arrange for a responsible adult to drive you home and stay with you for 24 hours after your procedure.

- To **AVOID CANCELLATION** of your surgery, please do the following **THREE** steps:

### Appointments

#### 1. Family Doctor

See your family doctor within 28 days of surgery to have a physical exam. Your physician will complete the “*Admission and Pre-Operative History and Physical*” form (# 211678).

#### 2. Forms

**Complete** the “*Pre-Op Surgical Questionnaire*” (# 211784) and “*Confidential Admission Form*” including insurance information (# H3759) which are in this package. Please bring these forms to your Pre-Admission Clinic appointment.

#### 3. Pre-Admission Clinic

**Bring:**  This package with above forms and all other contents  
 Your Health Card  
 Your Health Insurance Coverage information  
 Your medications in their original containers

***Bring this completed package with you to all your appointments***  
Medical Surgical Outpatients – 1st Floor – FAX: 905-338-4496

Name: \_\_\_\_\_

## DAY SURGERY at Oakville Trafalgar Memorial Hospital

### For Clinic Use Only

Date of Surgery: \_\_\_\_\_

Time to Arrive: \_\_\_\_\_

Surgical Services / Ambulatory Procedures Unit - 2<sup>nd</sup> Floor, Oakville Trafalgar Memorial Hospital (OTMH)

 **Reminder: Bring your package with you to all appointments.**

#### Instructions for the night before your surgery:

1. Please **DO NOT** have anything to eat or drink after midnight \_\_\_\_\_.  
Remember: no gum, candy or water during fasting time. If indicated, you may have clear fluids (e.g., black tea or coffee, water, apple juice, ginger ale) until 6 hours before your surgery time: \_\_\_\_\_. Please **DO NOT** drink *orange juice or milk* during this time.
2. Bring your completed Home Medication list. If requested, also bring all your daily medications.
3. These are the medications to take on the morning of your surgery:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Please **DO NOT** smoke the day before and for 2-3 days after your surgery. OTMH is a smoke-free facility.
5. You must remove all make-up, lipstick, nail polish, contact lenses, piercings and jewellery (see note on Page 3 "What Should I Wear").
6. Leave all your jewellery and valuables at home. We cannot be held responsible for lost or stolen items.
7. Please **DO NOT** wear perfume, cologne or other scented personal care products. The Oakville Trafalgar Memorial Hospital is a fragrance-free hospital environment.
8. Remember to bring your eyeglass case and denture cups, if you use these items.

*If you have any questions or concerns, contact the **OTMH Pre-Admission Clinic at 905-338-4497***

# CHLORHEXIDINE – CHD SHOWER INSTRUCTIONS BEFORE SURGERY

Department of Surgery



Purchase one 4oz (115mL) bottle  
Chlorhexidine gluconate 4% (CHD)  
from your local pharmacy


## DIRECTIONS:

Take **TWO** showers, **one** the **night before surgery** and **another** the **morning of surgery**

1. Remove all jewelry and body piercings.
2. Wash your hair and body using your normal soap and shampoo. Rinse. Step away from the water.
3. Wet a clean washcloth and apply **CHD** solution to the wet washcloth. Use half of the **CHD** for the first shower and half for the next one.
4. Wash your entire body **from the neck down** using the wet, soapy washcloth. Clean your belly button thoroughly with Q-tips and **CHD**, (wash your outer genital and anal areas last). Leave the solution on the skin for **3 minutes**, then rinse the cleaner thoroughly from your body.
5. Use a clean towel to pat your skin dry.
6. Dress in fresh clean sleepwear/clothes. Sleep in clean sheets the night before your surgery.

**If you have any questions or concerns,  
contact your surgeon**

## **DO NOT!**

- **Do not use** the Chlorhexidine  **near your eyes, ears, mouth or vagina**
- **Do not use** if you are allergic to Chlorhexidine; consult your surgeon
- **Do not** apply body moisturizing lotion or powder after your shower
- **Do not** shave, clip, or wax below your neck for 7 days before surgery

## **IMPORTANT!**

- If you experience any **signs of allergy**, for example, a rash, breathing difficulties, palpitations, or swelling of the lips, tongue and throat, or if you feel unwell in any way, **STOP** use and please seek medical advice immediately, visit your Emergency Department, family doctor, or call Telehealth Ontario (1-866-797-0000) or 911

**Accommodation requests will be based on availability at the time of admission.**

Have you received any treatment in this hospital before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your name changed since your previous visit? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please indicate previous name: _____
Family Physician	Attending Physician
Allergies	

Patient Information			Partner or Next-of-Kin Information		
Patient Surname		Given Name(s)	Surname		Given Name(s)
Date of Birth	Sex	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common-Law	Address		
Address			City	Province	Postal Code
City	Province	Postal Code	Home Phone		Cell Phone
Home Phone		Cell Phone	Work Phone		
Work Phone			Relation to Patient		
Employer Name and Address					
Preferred Language				Religion	
Do you have an Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Name and Phone Number: _____			

Hospital and Medical Insurances		
Health Card Number (10 digits)	Version Letters on Health Card	Surname and Initials as Shown on the Health Card
Accommodation	Coverage	
<input type="checkbox"/> Ward	<input type="checkbox"/> I do not have insurance coverage. Please bill me directly.	
<input type="checkbox"/> Semi Private (\$240.00)	<input type="checkbox"/> I have some coverage. Please bill my insurance company and bill me for any remaining balances	
<input type="checkbox"/> Private (\$270)	<input type="checkbox"/> I have full coverage. Please bill my insurance company directly	

*All self-pay accounts should be paid upon discharge.*

Extended Healthcare Benefit Insurance Information and Coverage		
Name of Insurance Company		
Surname and Given Name of Certificate Holder (as registered with insurance company)		Patient Relation to Insurance Holder <input type="checkbox"/> Holder <input type="checkbox"/> Child <input type="checkbox"/> Spouse
Group Policy Number	Identification or Certificate Number	Certificate Holder's Date of Birth
Employer Name		Employer's Address

***I understand it is my responsibility to verify my insurance coverage.***

Signature of Patient: \_\_\_\_\_ Signature of Registration Clerk: \_\_\_\_\_ Date: \_\_\_\_\_

## PRE-OP SURGICAL QUESTIONNAIRE

Patient Name					
Phone - Work	Phone - Home	Birth Date	Height	Weight	
Surgeon		Family Doctor			
Who completed this form: <input type="checkbox"/> Patient <input type="checkbox"/> Other - Name: _____ Date Completed (DD/MM/YY): _____ Relationship: _____					
1. Do you smoke? How many per day? _____ Number of years you have smoked: _____			YES <input type="checkbox"/>	NO <input type="checkbox"/>	
2. Have you ever smoked? Quit Date: _____			<input type="checkbox"/>	<input type="checkbox"/>	
3. Is it possible that you are pregnant?			<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you take Warfarin, Coumadin, Aspirin, Plavix or any blood thinner?			<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you taken prednisone cortisone or steroids in the past 12 months?			<input type="checkbox"/>	<input type="checkbox"/>	
<b>Do you have, or have you ever had, any of the following?</b>					
	YES	NO		YES	NO
6. Difficulty with neck movement or opening your mouth	<input type="checkbox"/>	<input type="checkbox"/>	19. Blackouts or fainting spells in the last year	<input type="checkbox"/>	<input type="checkbox"/>
7. Capped, loose or false teeth, or body piercings	<input type="checkbox"/>	<input type="checkbox"/>	20. Stroke, mini-stroke, severe muscle weakness, or paralysis of any part of your body	<input type="checkbox"/>	<input type="checkbox"/>
8. Asthma, bronchitis, COPD, TB	<input type="checkbox"/>	<input type="checkbox"/>	<b>Date:</b> _____		
9. Chronic or troublesome cough	<input type="checkbox"/>	<input type="checkbox"/>	21. Epilepsy, seizure or a significant neurological disorder. <b>Date of last seizure:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a) Shortness of breath at rest or when lying flat	<input type="checkbox"/>	<input type="checkbox"/>	22. Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you use oxygen at home?	<input type="checkbox"/>	<input type="checkbox"/>	23. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
11. Sleep apnea (stop breathing in your sleep) If "Yes", do you use CPAP/BIPAP?	<input type="checkbox"/>	<input type="checkbox"/>	24. Yellow jaundice, hepatitis, HIV or liver problems	<input type="checkbox"/>	<input type="checkbox"/>
12. Shortness of breath when walking up two flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	25. Rheumatoid arthritis (not osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>
13. Nausea or vomiting after an anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	26. Bruise or bleed excessively	<input type="checkbox"/>	<input type="checkbox"/>
14. a) An unusual or serious reaction to any kind of anesthetic (e.g., malignant hyperthermia)	<input type="checkbox"/>	<input type="checkbox"/>	27. Leg or lung blood clots or DVT	<input type="checkbox"/>	<input type="checkbox"/>
b) Does this apply to anyone else in your family?	<input type="checkbox"/>	<input type="checkbox"/>	28. Current low blood count, current anemia, or other blood disorder (e.g., sickle cell)	<input type="checkbox"/>	<input type="checkbox"/>
15. a) Heart problems such as heart murmur, valve replacement, or serious rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	29. Chronic or acute pain requiring prescription medication.	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you have a pacemaker/defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>	30. Hiatus hernia or significant problems with stomach acid or heartburn	<input type="checkbox"/>	<input type="checkbox"/>
16. Angina or heart attack <b>Name of Specialist:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	31. Kidney disease / dialysis	<input type="checkbox"/>	<input type="checkbox"/>
17. Chest pain with exercise	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you drink alcohol, wine, or beer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
18. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____		
			How often? _____		

## PRE-OP SURGICAL QUESTIONNAIRE

33. Do you use recreational drugs?  Yes  No Type \_\_\_\_\_ How often? \_\_\_\_\_

34. Have you been identified with MRSA or VRE in the past?  Yes  No  Don't Know

35. Do you or any family member have a history of prion disease such as CJD (Creutzfeldt-Jakob Disease)?  Yes  No  Don't Know

36. Who will drive you home and stay with you after discharge from the hospital?  
Name / Relationship: \_\_\_\_\_

37. List any major illnesses (including psychological) or operations you have had. Include **where and when** you had the operation

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

38. When was the last time you were in the hospital? \_\_\_\_\_  
Where? \_\_\_\_\_ Why? \_\_\_\_\_

39. When was the last time you had a general anesthetic? \_\_\_\_\_  
Name of hospital? \_\_\_\_\_

40. Are you allergic to latex?  No  Yes - Type of Reaction: \_\_\_\_\_

41. List all drug and food allergies

Allergic to	Reaction

41. List all medications you take **including** herbal and over-the-counter. (If applicable "Patient Family Recorded Home Medication List")

Drug	Dose	How often	Reason



For Hospital Use Only Below This Line

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Phone Assessment Required:  Yes  No

Appointment Scheduled:  Yes  No

## ADMISSION and PRE-OPERATIVE HISTORY AND PHYSICAL

Admission Date: \_\_\_\_\_  
 Date of Completion: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_

Presenting Complaint(s): \_\_\_\_\_  
 \_\_\_\_\_

CNS:	ENT:	Smoking: pack/day:	No. of Years:
PUL	CVS:	Alcohol: oz/day:	oz/week:
GI:	GU:	Occupation:	
MSS:	Other:		
Allergies:			
Medications and Dosage - Past and Current (steroids, antidepressants, betablockers, etc.)			

**Pre-Op** Since not all patients having surgery require an anaesthetic consult, please consult with the "Guidelines for Anaesthetic Consults" on the back of this form.  
 Georgetown / Milton Anaesthetic Consult Required:  Yes  No  
 If an anaesthetic consult is required, a "Request for and Record of Consultation" (form # 211519-000094) must be completed.  
 Please enclose copies of previous ECGs, echocardiogram and medical consults for patients with abnormalities  
 Oakville - NOTE: Cataracts under local generally do not require an anaesthetic consult  
 If an anaesthetic consult is required, a "Request for and Record of Consultation" (form # 211519-000094) must be completed and faxed to the Pre-Admission Clinic with this completed form.  
 Please fax copies of previous ECGs, echocardiogram and medical consults for patients with abnormalities (Fax: 905-338-4496). All anaesthetic consults will be arranged by the Pre-Admission Clinic,

<b>Past History</b>	<b>Operations and Anaesthetics</b>	<b>Significant Illnesses</b>
	Previous Surgery at HH: <input type="checkbox"/> No <input type="checkbox"/> Yes: Year of last surgery: _____ Pregnancy: G__ P__ A__ LMP: _____ Transfusion: <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Family History</b> (including operative or anaesthetic problems - bleeding, hyperthermia, etc.)	

<b>Physical</b>	Height:	Weight:	BMI:	Temp:	General:	
	H & N:	Breasts:				
	RS:					
	CVS	HR:	BP:	HS:	Murmurs:	Peripheral Pulses:
	ABD:					
	GU:					
	CNS	Mental:	Motor System:	Sensory System:	Reflexes:	
	MSS:	Skin:				

**DIAGNOSIS:** \_\_\_\_\_  
**Management** (include home support requirements): \_\_\_\_\_

\_\_\_\_\_  
**Physician Name**  
 \_\_\_\_\_  
**Signature**



### Guidelines for Anaesthetic Consultation

**Clinical evaluation will guide the decision for consultation. If the need for consultation is not clear, an anaesthetic consult should be requested. Please circle all indications.**

High Risk Procedures		Moderate Risk Procedures	
a) Thoracic surgery	d) Major Urological surgery	a) Major bowel surgery	c) Major plastic reconstructive surgery
b) Vascular surgery	e) Major head and neck surgery	b) Total Joint Replacements	d) Cataract surgery under GA (rare)
c) Caesarean Sections under GA			
Anaesthetic and Airway Problems		Patient Related Variables	Advance Analgesia for Post-Operative Pain
1. Potential Airway Problems a) History of difficult intubations b) Restricted neck movement or mouth opening c) TMJ surgery d) Oropharyngeal or laryngeal cancer +/- radiation to neck 2. Past Anaesthetic Problems a) Reaction to drugs, suspected drugs b) Post-op delirium, drowsiness, awareness, uncontrolled nausea & vomiting, inadequate pain control c) Respiratory insufficiency, prolonged ventilation 3. Malignant Hyperthermia (MH) 4. Family History of Anaesthetic Problems a) MH, Pseudocholinesterase deficiency		1. Patient Request 2. Language Barrier 3. Excessive Anxiety	1. Epidurals with LA/Narcotic 2. Intrathecal/Epidural Narcotics 3. Nerve Blocks/Catheter techniques with LA

#### Medical Problems

Cardiovascular		Respiratory	
a) Hypertension: (Systolic BP >180 and/or diastolic BP >110, poorly controlled), LVH, if end organ are affected b) Coronary Artery Disease (CAD), Angina, previous MI, CABG, abnormal ECG c) Congestive Heart Failure (CHF): any history d) Valvular Heart Disease, rheumatic fever and patients requiring antibiotic prophylaxis for heart disease e) Pacemakers, implanted cardioverter-defibrillator f) Arrhythmia g) Major vascular disease (suprainguinal) including Aortic Aneurysm disease, carotid artery stenosis h) Poor exercise tolerance < 2 blocks, 1 flight of stairs - not related to musculoskeletal problems i) Congenital Heart disease related to musculoskeletal problems j) Congenital Heart disease		a) COPD or asthma: poorly controlled disease, exercise tolerance <2 blocks, history of home oxygen/steroids/hospitalizations/ER visits within the past year b) Heavy Smoker (> 40 years) + productive cough c) Documented Sleep Apnea or 2 out of 3 symptoms (as per Berlin Questionnaire) d) Pulmonary restrictive disorders or prior lung surgery e) Hypoxemia SpO <sub>2</sub> < 93% f) History of tuberculosis	
Gastrointestinal		Renal	
a) Liver Disease: Hepatitis, Cirrhosis, Transplant recipients/candidates b) Oesophageal Disease: poorly controlled reflux or previous gastro-oesophageal surgery		a) Chronic renal failure b) Creatinine > 150 umol/L c) Hyperkalemia (K > 5.5) d) Other abnormal electrolyte or acid base disturbance	
Neurologic		Endocrine	
a) Epilepsy: poorly controlled b) Stroke: CVA/TIA c) Cerebral aneurysm, AVM d) Para/Quadriplegia e) Multiple Sclerosis f) Developmentally Challenged - autism, cerebral palsy, Down's Syndrome g) Parkinson's h) Dementia i) Prion disease (CJD - Creutzfeldt-Jakob Disease) or other inheritable spongiform encephalopathy (If "YES", notify ICPS and refer to CJD policy)		a) IDDM/poorly controlled NIDDM, the presence of end organ effects b) Thyroid: poor control or recent medication changes in (< 3 months) c) Adrenal or pituitary hyper or hypo function - Addison's disease, Conn syndrome, pheochromocytoma d) Iatrogenic steroids within the last 6 months (not inhaled, topical or joint injections) e) Carcinoid syndrome	
Hematologic/Oncologic		Musculoskeletal	
a) Coagulopathy, INR > 1.3 (an not on Coumadin), platelets < 100 b) Cancer - cachexia, metastasis, chemotherapy, radiation c) Transfusion reactions d) Sickle cell disease (not trait) / Thalassemia e) Immunosuppression		a) Connective tissue disorders - RA, SLE, Scleroderma b) Ankylosing Spondylitis c) Myasthenia Gravis d) Myotonia e) Muscular Dystrophy	
Infectious / Colonization		Size Related Disorders	
a) Bloodborne pathogens b) Acute respiratory illness and/or gastro c) MRSA/VRE		c) BMI > 40 - morbid obesity d) Bulimia, Anorexia	
Drug Use/Abuse			
a) Alcohol Abuse b) Marijuana c) Narcotic Use (> 6 months) - addiction, abuse, tolerance			







# Patient / Family-Recorded Home Medication List

## Why create a Home Medication List?

Your Home Medication List is a tool to help you and your family keep track of all the medications you are taking. It is important to write down everything, including vitamins and supplements, so your healthcare team can provide you with the best possible care. Certain medications might interact with another medication on your list; so, it is important that your Home Medication List be correct and up-to-date.

## Instructions for Patient or Family:

1. List **ALL** prescription medications, non-prescription medications, vitamins, herbal and naturopathic products, and/or drug trials.
2. Write the dosage of each medication.
3. For each medication write the number of pills you take at the listed times. See examples.
  - If your medication time is not listed, write the time you take it in the “Other” column
4. If the name of medication is unknown, describe pill under “Medication Name”, and indicate why you are taking it.
5. Your list will be photocopied and put on your hospital file.
6. Always keep a copy of your *Home Medication List* with you.
7. If you stop taking something or start a new medication, be sure to update this list.
8. If you have any questions about your medication or filling out this form, contact your doctor or pharmacist.

## EXAMPLES:

Medication Name	Dose or Strength	AM	Noon	PM	Bedtime	Other	As Needed
Metformin	500mg	2		2			
Tylenol Arthritis	650mg					1 at 10:30 am	
Natural Tears	1 drop in left eye						√
Hydrocortisone Cream	0.1% To arm				1		
Vitamin D	1000 units	1					



## Patient Instructions

# Preventing Surgical Site Infections

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### **Fact Sheet for Surgical Patients and Families**

This fact sheet provides basic information only. It must not take the place of medical advice, diagnosis or treatment. Always talk to your health care professional about any health concerns you have, and before you make any changes to your diet, lifestyle or treatment.

### **What Are Surgical Site Infections (SSIs)?**

Surgical site infections occur when harmful germs or bacteria enter your body through the surgical site (any cut the surgeon makes in the skin to perform the operation). Infections happen because germs are everywhere - on your skin, in the air and on things you touch. Most infections are caused by germs found on and in your body. This fact sheet describes some measures we can all take to prevent SSIs but, despite all prevention efforts, they can sometimes still occur.

### **What Are The Symptoms of SSIs?**

- Increased soreness, pain, or tenderness at the surgical site
- A red streak, increased redness, or puffiness near the incision
- Greenish-yellow or bad-smelling discharge from the incision
- Fever of 101 degrees Fahrenheit or 38 degrees Centigrade or higher
- A tired feeling that won't go away

Symptoms can appear at any time from hours to weeks after surgery. Implants such as an artificial knee or hip can become infected a year or more after the operation. Make sure you contact your health care provider if you suspect you have an infection.

### **What Are The Risk Factors For SSIs?**

The risk of acquiring a surgical site infection is higher if you:

- are an older adult;
- smoke;
- have a weakened immune system or other serious health problem such as diabetes;
- are malnourished (don't eat enough healthy food);
- are very overweight

## Preventing Surgical Site Infections

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### **What Is Being Done To Prevent SSIs?**

The following precautions to prevent SSIs are being taken by your healthcare providers:

**You can help too** (see number 6 and 7 below)!

1. Practicing proper hand washing techniques. Before the operation, the surgeon and all the operating room staff scrub their hands and arms with an antiseptic soap.
2. Cleaning the site where your incision is made with an antiseptic solution.
3. Wearing medical uniforms (scrub suits), long-sleeved surgical gowns, masks, caps, shoe covers and sterile gloves.
4. Covering you with a sterile drape with a hole where the incision will be made.
5. Giving you an antibiotic preoperatively, if needed.
6. Closely watching your blood sugar levels very carefully, especially if you are a diabetic. Keeping them within a normal range helps to support good wound healing.
7. Keeping you warm before, during and after your operation is important. Maintaining a close to normal body temperature ensures good oxygenation of the tissues and this promotes wound healing.

Warmed IV fluids and warm blankets are available and may be provided by the hospital staff.

You can help keep yourself warm before the procedure by bringing in warm socks or slippers.

8. Do not shave hair from the incision site or use a hair removal product! If hair must be removed, the surgeon makes this decision and special clippers, which do not touch the skin, are used to remove hair. You can help by **not shaving the area of the incision for at least 1 week prior to your surgery!**

*This handout is for self-care. It should not to be used to replace a visit with your healthcare provider.  
If you have questions about your personal medical situation, please call your healthcare provider.*