Patient Name: ________________________________

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

In-Patient 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
  If you are an OBSTETRICAL patient, please call 905-338-4662 for a pre-natal appointment

Pre-Admission Clinic Appointment:
Date: ____________________________ Time: ____________________

- 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
Medcal Surgical Outpatients – 1st Floor – FAX: 905-338-4496

Oakville Trafalgar Memorial Hospital

Name: ___________________________________

IN-PATIENT SURGERY
at Oakville Trafalgar Memorial Hospital

For Clinic Use Only

Date of Surgery: ____

Time to Arrive: ____

Surgical Services / Ambulatory Procedures Unit - 2nd 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

Halton Healthcare
GEORGETOWN • MILTON • OAKVILLE

Oakville Trafalgar Memorial Hospital

CONFIDENTIAL ADMISSION FORM

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

Have you received any treatment in this hospital before? ❒ Yes ❒ No	Has your name changed since your previous visit? ❒ Yes ❒ 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 ❒ Single ❒ Separated ❒ Married ❒ Divorced ❒ Widowed ❒ 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? ❒ Yes ❒ No	Do you have a Living Will? ❒ Yes ❒ No	Do you have a Substitute Decision Maker ❒ Yes ❒ 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**
❒ Ward	❒ I do not have insurance coverage. Please bill me directly.
❒ Semi Private ($240.00)	❒ I have some coverage. Please bill my insurance company and bill me for any remaining balances
❒ Private ($270)	❒ 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 ❒ Holder ❒ Child ❒ 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:

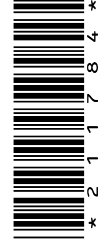
❒ Patient ❒ Other - Name: ____________ Date Completed (DD/MM/YY): ____________

Relationship: ____________

	YES	NO
1. Do you smoke? How many per day? ____________ Number of years you have smoked: ____________	❒	❒
2. Have you ever smoked? Quit Date: ____________	❒	❒
3. Is it possible that you are pregnant?	❒	❒
4. Do you take Warfarin, Coumadin, Aspirin, Plavix or any blood thinner?	❒	❒
5. Have you taken prednisone cortisone or steroids in the past 12 months?	❒	❒

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

	YES	NO		YES	NO
6. Difficulty with neck movement or opening your mouth	❒	❒	19. Blackouts or fainting spells in the last year	❒	❒
7. Capped, loose or false teeth, or body piercings	❒	❒	20. Stroke, mini-stroke, severe muscle weakness, or paralysis of any part of your body **Date:** ____________	❒	❒
8. Asthma, bronchitis, COPD, TB	❒	❒			
9. Chronic or troublesome cough	❒	❒	21. Epilepsy, seizure or a significant neurological disorder. **Date of last seizure:** ____________	❒	❒
10. a) Shortness of breath at rest or when lying flat	❒	❒	22. Thyroid problems	❒	❒
b) Do you use oxygen at home?	❒	❒	23. Diabetes	❒	❒
11. Sleep apnea (stop breathing in your sleep)	❒	❒	24. Yellow jaundice, hepatitis, HIV or liver problems	❒	❒
If "Yes", do you use CPAP/BIPAP?	❒	❒			
12. Shortness of breath when walking up two flights of stairs	❒	❒	25. Rheumatoid arthritis (not osteoarthritis)	❒	❒
			26. Bruise or bleed excessively	❒	❒
13. Nausea or vomiting after an anesthetic	❒	❒	27. Leg or lung blood clots or DVT	❒	❒
14. a) An unusual or serious reaction to any kind of anesthetic (e.g., malignant hyperthermia)	❒	❒	28. Current low blood count, current anemia, or other blood disorder (e.g., sickle cell)	❒	❒
b) Does this apply to anyone else in your family?	❒	❒			
15. a) Heart problems such as heart murmur, valve replacement, or serious rhythm disorder	❒	❒	29. Chronic or acute pain requiring prescription medication.	❒	❒
b) Do you have a pacemaker/defibrillator?	❒	❒			
16. Angina or heart attack **Name of Specialist:** ____________	❒	❒	30. Hiatus hernia or significant problems with stomach acid or heartburn	❒	❒
17. Chest pain with exercise	❒	❒	31. Kidney disease / dialysis	❒	❒
18. High blood pressure	❒	❒	32. Do you drink alcohol, wine, or beer? ❒ Yes ❒ No 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

211784

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.

Anaesthetic Consult Required: ☐ Yes ☐ No

Georgetown / Milton

- 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,

Past History

Operations and Anaesthetics	Significant Illnesses
Previous Surgery at HH: ☐ No ☐ Yes: Year of last surgery: ______	Pregnancy: G___ P___ A___ LMP: __________ Transfusion: ☐ Yes ☐ No

Family History (including operative or anaesthetic problems - bleeding, hyperthermia, etc.)

Physical

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

DIAGNOSIS:

Management (include home support requirements):

____
Physician Name

____
Signature

2116787

Guidelines for Anaesthethic 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 b) Vascular surgery c) Caesarean Sections under GA d) Major Urological surgery e) Major head and neck surgery	a) Major bowel surgery b) Total Joint Replacements c) Major plastic reconstructive surgery d) Cataract surgery under GA (rare)

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/ordiastolic 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 cardiovertor-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_2 < 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	Endrocrine
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, phaeochromocytoma d) Iantrogenic steroids within the last 6 months (not inhaled, topical or joint injections) e) Carcinoid syndrome

Hernatologic/Oncologic	Musculoskeletal
a) Coagulopathy, INR > 1.3 (an not on Cournadin), platelets < 100 b) Cancer - cachexia, metastasis, chemotherapy, radiation c) Transfusion reactions d) Sickle cell disease (not trait) / Thalassaernia e) Immunosuppression	a) Connective tissue disorders - RA, SLE, Scleroderma b) Ankylosing Sponcylitis c) Myaesthenia 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	

If you have your own medication list with you, you do not have to fill out this form.

Patient / Family-Recorded Home Medication List

Date Recorded: ____________________________________

Pharmacy name and phone number:

Allergies (Describe Reaction): ❒ **No Known Allergies**

Currently Taking Medications / Supplements at Home?
❒ **No** ❒ **Unknown**

Medication Name	Dose or Strength	When do you take your medications?					
		A.M.	Noon	P.M.	Bedtime	Other	As Needed

H3760-MED

COMPLETED BY: ❒ Patient ❒ Family ❒ Health Care Professional

Help Us Keep You Safe – Know Your Medications!

See over →

Patient / Family-Recorded Home Medication List

Why create a Home Medication List?

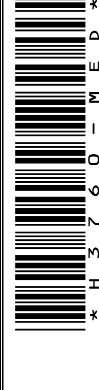
Your Home Medication List is a tool to help you and your family keep track of all the medications you are taking. It is important to write down everything, including vitamins and supplements, so your healthcare team can provide you with the best possible care. Certain medications might interact with 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					



Help Us Keep You Safe – Know Your Medications!

Patient Instructions

Preventing Surgical Site Infections

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

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.