Patient Name: _____

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

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

Form # DE017

Level 1 North
Block
Go to
Park in LOT 6

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

Name: _____

DAY SURGERY
at Oakville Trafalgar Memorial Hospital

For Clinic Use Only

Date of Surgery: _____

Time to Arrive: _____

Go to G Level 2 Centre Block

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 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***

What is Day Surgery/Surgical Day Care?

Day Surgery means that you will be having a surgical procedure and be discharged home on the same day. Because of improvements in medicine, anaesthesia and technology, many surgical procedures do not require you to stay in the hospital overnight.

What is a Pre-Admission Appointment?

The pre-admission appointment is important to prepare you for surgery. It includes speaking with a Registered Nurse who will arrange any blood tests, x-rays or other tests that may be required. This appointment will take approximately 60 minutes. The appointment may be longer if you are required to see the anaesthetist.

On the day of your pre-admission appointment, you may eat and drink as usual.

Please bring the following with you to your Pre-Admission Clinic visit:

Item	Details
Your Pre-Admission Clinic Package	Given to you by the surgeon.
Admission History and Physical form.	**Completed by your family doctor** within 28 days before the date of surgery.
Pre-Operative Surgical Questionnaire	**Completed by you** BEFORE your pre-admission visit.
Confidential Admission form	**Completed by you** BEFORE your pre-admission visit.
All the medications you are currently taking, or a list with the names and times you take them.	
Your Ontario Health card	

What if my health changes before surgery?

If you do not feel well or there is a change in your health before your surgery, please call your surgeon's office as soon as possible. For example, if you have a cold or other illness, discuss this with your surgeon.

What should I do on the day of surgery?

On the day of your surgery, you should report to the Surgical Services/Ambulatory Procedures Unit located on the 2nd floor. Follow the signs provided throughout the hospital.

Please arrive at the time that you have been instructed during your Pre-Admission visit. Be aware that, if you are late, your surgery may be delayed or re-scheduled. Occasionally, the time of your surgery may change. The Pre-Admission Clinic will notify you of any time changes one business day before your surgery.

Important:
The Operating Room may be needed for life threatening emergencies. Although this does not occur often, we do not know in advance when these emergencies are going to occur. If an emergency does happen, the time or date of your surgery may be changed. You will be notified of any changes as soon as possible.

What should I wear?
Please wear loose fitting clothing and flat shoes. We will provide you with a hospital gown. Do not wear make-up, nail polish, contact lenses or any jewellery, including all piercings. If you cannot remove any jewellery/piercing, please have it professionally removed prior to your surgery day, due ***to a risk of surgical burn related to cautery use and potential circulation impairment due to swelling.*** You can wear hearing aids, dentures and glasses, but you will be asked to remove them before surgery. Please bring a hearing aid case, a denture cup and a case for your glasses, if needed.

On the Day of your Surgery
We will ask you to change into a hospital gown. You will be seen by a nurse who will ask you a few questions and will take your pulse, temperature and blood pressure. The nurse will start an intravenous line in your hand.

The Patient Waiting Area
You will wait in the patient waiting area. From this area, we will take you to the Operating Room.

Operating Room
We will help you onto the operating table. We will put a blood pressure cuff on your arm, an oxygen monitor on your finger, a heart monitor on your chest and a mask on your face to deliver oxygen. At this time, you will be involved in the briefing portion of the Surgical Safety Checklist. Then, you will be given an anaesthetic.

Post Anaesthetic Care Unit (PACU)
You may be taken to the Post-Anaesthetic Care Unit (sometimes referred to as the Recovery Room) after your surgery. Whether or not you are taken to the PACU depends on the type of anaesthetic you had. The PACU is a large room and there may be several other patients in the room with you. During your stay in the PACU, you will probably hear the constant beep and whirl of the many machines that are monitoring patients. You may also see and hear a number of nurses and physicians going about their business.

The PACU nurses will measure your pulse, breathing and blood pressure frequently. You will wake up in the PACU. You may have an oxygen mask over your mouth and nose. Your stay in the PACU will be between half (1/2) an hour and two (2) hours, depending on the type of surgery you have had.

After PACU, you will return to Surgical Day Care. When you have recovered from the anaesthetic, you will be offered a drink of juice or ginger ale.

Discharge Instructions

In order to be discharged, you must have a responsible adult relative or friend take you home after your surgery. ***It is important that this adult be available at your discharge time.*** They must also stay with you for at least 12 to 24 hours after your surgery.

Before you leave, a nurse will go over your instructions on how to take care of yourself at home.

IMPORTANT!

You must arrange for someone to escort you home from the hospital. If you do not have a responsible adult to take you home, your surgery will be cancelled. You and your friend or relative must go home by car or taxi, **NOT** by public transit.

For your safety:

Even though you are awake soon after your day surgery, you may feel drowsy for 24 to 48 hours after the surgery.

It is important that you **DO NOT:**

- drive a car or operate hazardous machinery for 24 hours
- drink alcohol for 24 hours
- take any medication unless prescribed by your physician
- make any important or legally binding decisions until you have recovered

Please, make plans to ***GO STRAIGHT HOME*** and rest for the day following your surgery. Arrange to have a responsible adult stay with you to ensure that you are okay.

Other Appointments

Date: _____

Time: _____

Location: _____

Date: _____

Time: _____

Location: _____

Date: _____

Time: _____

Location: _____

NOTES:

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

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

PATIENT TO COMPLETE

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	❒ I have some coverage. Please bill my insurance company and bill me for any remaining balances
❒ Private	❒ 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: _____

Please fill out the front and back of this form

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

PATIENT TO COMPLETE

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? _____		

211784

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

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

PATIENT TO COMPLETE

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 →

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

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					

H3760-MED

Help Us Keep You Safe – Know Your Medications!

Halton Healthcare Services
Georgetown / Milton / Oakville

ADMISSION and PRE-OPERATIVE HISTORY AND PHYSICAL

FAMILY DOCTOR TO COMPLETE 1-3 WEEKS PRIOR TO SURGERY

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,

Past History

Operations and Anaesthetics	**Significant Illnesses**
Previous Surgery at HHS: ☐ 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 → 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

2116788

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

CONSENT TO TREATMENT

Patient Name (Print): _____

Treatment/Procedure (Print): _____

_____

_____

Consent Statement

I have discussed with Dr. Sandeep Sharma and understand:
Treatment Proposer (Print - Name and Designation)

- the reason for the above treatment and what will happen during the treatment as explained to me;
- the intended effect of the treatment and the significant risks that might occur with the treatment;
- any other possible options for care and likely risks of not having the treatment.

By signing this form, I agree:

- to additional treatments, tests, or operations that are considered necessary to this treatment;
- to other physicians/hospital staff to provide or assist in my treatment;
- to student and trainee supervised involvement in my treatment;
- to be given general anesthetics, sedation or other anesthethics for the above treatment as may be needed;
- that I have had the chance to ask questions, and these questions have been answered to my satisfaction;
- I consent to treatment.

I acknowledge that any tissues or parts surgically removed may be disposed of in accordance with usual practice.

_____ _____
Signature of Patient Date

_____ _____
Signature of Substitute Decision Maker (if required) Substitute Decision Maker Name (Print)

_____
Relationship to Patient

Interpreter Used In Discussion: ❒ Yes ❒ No

211808

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

CONSENT TO TREATMENT

Consent To Blood Products / Components

- ☐ I consent to receive blood components prepared from donor blood (e.g., red cells, platelets, plasma)
- ☐ I do **NOT** consent to receive blood components prepared from donor blood (e.g., red cells, platelets, plasma)
- ☐ I consent to receive *manufactured* blood products prepared from donor blood (e.g., albumin, immune globulin, coagulation products)
- ☐ I do **NOT** consent to receive *manufactured* blood products prepared from donor blood (e.g., albumin, immune globulin, coagulation products)

_____
Signature of Patient or Substitute Decision Maker

Statement Of Consent Obtained By Telephone

I have obtained by telephone the consent given by _____
Name of Substitute Decision Maker, Relationship to Patient, Telephone Number (Print)

acting as Substitute Decision Maker for _____ to the above mentioned treatment.
Name of Patient (Print)

_____ _____ _____
Treatment Proposer (Signature) Treatment Proposer (Print) Date

Emergency Treatment Without Consent

If, in the opinion of the health care professional, a delay for the purpose of obtaining consent would put the person at risk of serious bodily harm or prolonged suffering, the health care professional should complete the following statement:

I, _____ believe/believed that the delay in obtaining
Treatment Proposer (Print - Name and Designation)

consent to perform _____ would/would have put
Treatment / Procedure (Print)

_____ at risk of serious bodily harm or prolonged severe suffering.
Patient Name (Print)

_____ _____ _____
Treatment Proposer (Signature) Treatment Proposer (Print) Date

211808

Halton Healthcare

Oakville Trafalgar Memorial Hospital

ALLERGIES
❒ NKA ❒ or : _____

Family Physician	***Most Responsible Physician*** (to be completed by MRP on admission and whenever there is a transfer of care)	***Consultants*** 1. _____ 2. _____

Physician's Orders

M = MAR **OE** = Order Entry
K = Kardex **N** = Notified
ORDER PROCESSED (✓)

Use	daily	every other day	mL or millilitre	Unit	full drug name	mcg	right, left, both eye(s)
Do not Use	OD/QD	QOD	cc	U or IU	Abbreviated drug name	µg	OD, OS, OU

Date	Time	***Consider DVT Prophylaxis***	M	K	OE	N	Init

211803

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

REQUEST FOR AND RECORD OF CONSULTATION

TO: _____ FROM: _____
Consulting Physician — Referring Physician

❒ Consultant Notified ❒ Consultant Not Notified
Date: _____ Time: _____

STATUS: ❒ Urgent ❒ Consultation Only
❒ Elective ❒ Consultation and Daily Care

REFERRING PHYSICIAN'S NOTE: _____

_____

_____

_____ _____
Date **Signature of Referring Physician**

CONSULTING PHYSICIAN'S NOTE: _____

_____ _____
Date **Signature of Consulting Physician**

Note Dictated: ❒ Yes ❒ No Date: _____ Time: _____