SHARP

Patient Database – Section One: Home Medications

(Not a Physician's Order Form)

☐ Check if this sheet is an addition to the medication list obtained on admission

Patient Name: _____ Date of Birth: ____/____/____

☐ Patient takes no medications

☐ Home medication information unavailable

Medication Allergies/Intolerances	Describe Reaction

List all **prescription medications** starting with heart, blood pressure, blood thinners, inhalers and diabetes (insulin), eye drops, etc. and **over-the-counter medications** such as vitamins, aspirin, and herbs

	Medication	Dose	How Taken	How Often	Last Dose Taken	Comments (Why do you take?)	Source of Info*	Discharge Status** Physician to circle
1								Take Stop
2								Take Stop
3								Take Stop
4								Take Stop
5								Take Stop
6								Take Stop
7								Take Stop
8								Take Stop
9								Take Stop
10								Take Stop
11								Take Stop
12								Take Stop

*Source of info: P = Patient, F = Family, O = Other

**Take = No changes - Take as previously directed (obtain refills from primary doctor); Stop = Stop Drug or Dose

Admission Medication Review

Reviewed with Patient/Family (Name of individual) _____/_____ Date_____ Time_____

RN Signature

Physician is aware of home meds as reported by the source listed above

_____ Date_____ Time_____

Physician signature (or RN Signature with physician name, if reviewed with physician via phone)

Discharge Medication Reconciliation

☐ I have made no changes to the home meds

☐ I have written discharge prescriptions for this patient

☐ I have given the following discharge prescriptions to patient pre-operatively:_____

_____ Date_____ Time_____

Physician Signature

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Date:	Time:	Height: (required)	(inches)	Weight: (required)	(lbs or kg) Circle Parameter
Name preferred to be called:					
Information source if not patient:				If source "None" within 24 hrs. Reason:	
Do you speak and understand English? ☐No ☐Yes				Do you need an interpreter? ☐No ☐Yes	
Primary Language Spoken:					
Emergency Contact/Spokesperson:				Relationship:	
Preferred Phone Number:				Alternative Phone Number:	
Why are you in the hospital?					
Who is your primary care physician?				Last Visit/Exam (Date):	
How can we provide **'Very Good'** care for you during your hospital visit?					
☐No ☐Yes	Do you have any special requests regarding visitors? Describe:				
☐No ☐Yes	Are you **allergic** to **latex** or **rubber**? Reaction: **(If yes, Implement Latex Precautions)**				
☐No ☐Yes	Are you **allergic** to **iodine** or **x-ray dye**? Reaction:				
☐No ☐Yes	Are you **allergic** to **tape**? Reaction:				
☐No ☐Yes	Do you have sensitivity to sulfites (food preservatives) or any **food allergy**? Type:		Reaction:		
☐No ☐Yes	Do you use illicit (street) drugs? Type:		How much:	Last used?	
☐No ☐Yes	Do you have more than 10 alcoholic drinks per week? If yes, how many?				
☐No ☐Yes	Do you follow a bowel program at home? Type:			Date of last BM?	
☐No ☐Yes	Have you had any on-going problems with pain in the recent past? (last 7-14 days)				
☐No ☐Yes	Do you currently have pain?				
☐No ☐Yes	If yes, Is it related to the current hospitalization? **(If yes, Complete section below)**				

Comprehensive Pain Assessment

Pain location:	Origin/Cause of pain:	
Onset (date/time):	Pain scale used:	
Pattern:	Quality:	
Pain intensity: Currently:	At worst:	At best:
What makes the pain worse?		
What makes the pain better?		
Is current pain regimen effective?	Acceptable level of pain:	

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Please answer the following questions: (If yes, nursing action required)		**Referral** (Gray Areas for Staff Only) *Initial when completed*
1. Do you have any religious/cultural practices or food preferences / special diet that need to be part of your care? If yes, describe: _____	☐No ☐Yes	____ If yes to 1, order nutrition level 2 screen.
2. Would you like a spiritual advisor (Priest, Rabbi, etc) to visit you?	☐No ☐Yes	____ If yes to 2, contact Pastoral Care.
3. Do you use or are you interested in receiving Integrative Therapies during this hospitalization?(Reiki, acupuncture, etc) If yes, describe: _____ (May not be available at all facilities)	☐No ☐Yes	If yes to 3, order integrative services & initiate care plan.
4. Do you have objections to receiving blood products? If yes, describe: _____	☐No ☐Yes	____ If yes to 4, have patient sign blood refusal form.
5. Do you have an Advance Directive (Living Will, etc)?	☐No ☐Yes	____ If yes to 5, request copy for chart.
6. If you do not have an Advance Directive, would you like assistance in developing one?	☐No ☐Yes	____ If yes to 6, contact Patient Relation/ Social Service.
7. Have you been eating less than half of your usual meals during the past week? (Other than a Doctor's order not to eat.)	☐No ☐Yes	If yes to 7, order nutrition level 2 screen & initiate care plan.
8. Do you have difficulty eating or do you cough or choke while swallowing food/liquids?	☐No ☐Yes	
9. Do you have a New problem with understanding, communicating or talking?	☐No ☐Yes	___ If yes to 8 or 9, request MD order for Speech consult & initiate care plan.
10. Do you currently have a cough with bloody sputum or night sweats which lasted over 2 weeks, and/or fever? (TB Screening)	☐No ☐Yes	____ If yes to 10, requestMD order for AFB isolation & initiate care plan.
11. Have you had a recent change in your ability to walk; or get out of bed or chair? If yes, describe: _____	☐No ☐Yes	If yes to 11, request MD order for PT consult & initiate care plan.
12. Have you had recent decrease in your ability to do your self care activities? (For example: washing, grooming, or dressing) If yes, describe: _____	☐No ☐Yes	If yes to 12, request MD order for OT consult & initiate care plan.
13. Are you in relationship in which you have been hurt, threatened, or scared?	☐No ☐Yes	If yes to 13, contact Social Service.
14. Have you smoked within the last 12 months? Packs a day? _____ Began? _____ Last used? _____	☐No ☐Yes	____ If yes to14, initiate smoking cessation education.
15. Do you currently have an Intravenous device (PICC line, Midline, Port) in your arm or chest; or any other catheter in your chest or neck?	☐No ☐Yes	____ If yes to 15, notify VAS team if inpatient.
16. Have you had a vaccination within the past 5 years for Pneumonia? If yes, Date of vaccine: _____	☐No ☐Yes	
17. Have you had a vaccination within the past 1 year for Influenza? If yes, Date of vaccine: _____	☐No ☐Yes	If No to 16 or 17, notify Case Management or follow Policy and Procedure.
18. Do you currently have Home Health Services visiting you? If yes, agency name_____	☐No ☐Yes	
19. Do you live anywhere other than a private residence? If yes, name of facility_____	☐No ☐Yes	____ If yes to 18 or 19, contact Case Management.

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20. Medical History (check all that apply and provide additional comments below or on back) ☐NONE

☐High blood pressure_____	☐Fainting/Loss of consciousness (Date)_____
☐Chest pain or Angina (Date)_____	☐Hiatal hernia_____
☐Heart attack (when)_____	☐Acid reflux or Ulcers_____
☐Heart bypass, Angioplasty, Stent (Date)_____	☐Hepatitis, Cirrhosis or Jaundiced_____
☐Heart failure_____	☐Kidney failure/Dialysis (Date)_____
☐Palpitations or Irregular heart beat_____	☐Rectal bleeding, black or bloody stool_____
☐Heart murmur or Heart valve problem_____	☐Easy bruising or bleeding_____
☐Difficulty breathing, Shortness of breath, Sleep apnea_	☐Phlebitis or Blood clot problem_____
☐Asthma, Emphysema, COPD_____	☐Blood disorders(Sickle Cell Anemia, Thalassemia)_____
☐Recent flu or Productive cough_____	☐Vision impaired_____
☐Smoker: Packs per day___Years used_____Quit?___	☐Hearing Impaired_____
☐Pneumonia (Date)_____	☐Mental health issues_____
☐Tuberculosis_____	☐Back or Neck pain/problems_____
☐Diabetes Mellitus_____	☐Arthritis_____
☐Thyroid Disease_____	☐Chronic pain_____
☐Brain surgery /Injury_____	☐Cancer, Chemotherapy/Radiation (Date)_____
☐Headaches/Migraines_____	☐Skin problem_____
☐Dementia /Alzheimer's Disease_____	Female only:
☐Stroke (Date)_____	☐Currently/Possibly pregnant_____
☐Prolonged Nerve paralysis or Numbness_____	☐Currently Breastfeeding_____
☐Epilepsy or Seizures (Date)_____	☐Last menstrual period (Date)_____

Comments: _____

Pre-Anesthesia Information (If you have taken illicit/street drugs, please let the anesthesiologist know, it may affect your anesthesia.)

21. Have you had any problems with previous anesthetics? ☐No ☐Yes Describe:
22. Have any of your blood relatives had unusual reaction to anesthetics? ☐No ☐Yes Describe:
23. Have you taken prednisone or steroids in the last 6 months? ☐No ☐Yes
24. Do you become short of breath when you climb two flights of stairs? ☐No ☐Yes
25. Do you have a Pacemaker or Internal defibrillator? ☐No ☐Yes Date last checked:_____
    Make: Model: Cardiologist:

26. Do you have any of the following?

Difficulty moving your head and neck?	☐No ☐Yes	Removable dentures?	☐No ☐Yes
Difficulty fully opening your mouth?	☐No ☐Yes	A false eye or limb?	☐No ☐Yes
Loose or chipped teeth?	☐No ☐Yes	Contact Lenses?	☐No ☐Yes
Permanent crowns/veneers/caps on your teeth?	☐No ☐Yes	Hearing Aid?	☐No ☐Yes

27. Have you had any previous operations? If numerous, list last 6 only.

Operation:	Date:	Operation:	Date:
Operation:	Date:	Operation:	Date:
Operation:	Date:	Operation:	Date:

Completed by:_____ Date/Time_____
Print Name

Reviewed by:_____ Date/Time_____
Nurse Signature

PATIENT IDENTIFICATION

SAN DIEGO
HANDSPECIALISTS
CARE OF THE HAND & UPPER EXTREMITY

STATEMENT OF COMPREHENSION

INSTRUCTIONS

Read this form completely. **INITIAL** each paragraph. If you agree with the statements, **WRITE "I UNDERSTAND"** on the line *above* your signature and **SIGN** where indicated at the bottom of the page. You MUST bring these papers to our office at the time of your Pre-Operative Visit.

Dear Patient:

☐ The reasons for undertaking this operation, anticipated goals, and possible complicating factors, and alternative methods of treatment have been discussed with you previously. We feel strongly that a patient wants to know what his or her medical problem is; expressed in terms you can understand. We have, therefore, tried to explain our proposed treatment in lay terms, so that you may understand the nature of your condition and the goals of the surgical treatment you have requested. If you have any questions about your procedure, please discuss them with us.

☐ Most orthopaedic procedures are done to arrest pain, to improve function, to prevent or correct an abnormal situation. Some times an exploratory type procedure is necessary when the exact diagnosis cannot be made with the usual clinical tools available to us. Some conditions can be treated non-operatively as well as operatively – often with the same results or similar results. The operative's choice of treatment, therefore, is based on medical knowledge and experience, and the patient's understanding of the problem. We have discussed these methods with you.

☐ All forms of treatment have certain risks associated with them. Some are far more risky than others. We have attempted to explain the risks and possible complications of your proposed operation with you. If you do not understand them or have some concern about some not mentioned, please ask us. Operations on nerves are particularly difficult for the patient and surgeon. Complaints of pain can be frequently relieved with surgical treatment. In some cases, however, pain does not subside and may become worse even though the operation is well performed and no specific injury or accident occurs during the procedure. This is because of the particular sensitive nature of nerves and the fact that internal nerve scarring may have occurred as a result of nerve compression. This internal scarring cannot be relieved with external decompression in all cases. The patient should understand that operations involving nerves carry a specific risk for persistent pain and/or weakness despite appropriate surgical intervention. If this is of concern to you, please discuss this with your surgeon.

☐ The responsibility for your surgical anesthetic will be undertaken by an anesthesiologist. You are encouraged to discuss the benefits, alternatives and possible complications with the anesthesiologist prior to your operation.

☐ _____ (← fill in Dr.'s name) has and ownership interest in _____ (← fill in facility name). You may choose another facility for your operation. If this is a concern, please discuss this with your surgeon.

☐ Some Orthopaedic & Hand Surgery operations require the use of metal plates, screws, pins & joint implants. All materials that remain in your body will experience wear and mechanical strain. These materials, regardless of high standards of manufacturing, may break loose, loosen, wear out, or become infected. In some cases your surgeon will advise removing a device when its job is done. This is a routine consideration when using implantable materials. If you have a concern about implant failure or need for removal, please discuss this with your surgeon.

_____

Patient Statement of Comprehension (please print "I UNDERSTAND" on the line above)

_____

Patient Name (please PRINT on the line above)

_____ ***Date:*** _____

Patient Signature (please SIGN on the line above)