az monica

AZ MONICA	DEPARTMENT OF ANESTHESIA
CAMPUS ANTWERPEN	CAMPUS DEURNE

PRE-OPERATIVE FILE
INFORMATION BROCHURE, QUESTIONNAIRE and INFORMED CONSENT

Information for the referring physician, surgeon or general practioner

Dear colleague, as a surgeon, or general practioner you are particularly involved in the peri-operative process. The department of anesthesiology, kindly requests you to complete the pre-operative file of your patient, using the “presurgical diagram” in supplement (the diagram is available in laminated version and will be sent to you by simple request).

To define the surgical risks and adjust the anesthetic management to the medical condition of the patient, the completing of the pre-operative file is essential. The pre-operative bilan is also important to correctly fill in the secondary diagnosis in the "ICD-9"-file of your patient.

Please mention all currently relevant data concerning secondary diagnoses **and** the medical history of your patient as well as recent reports concerning comorbidity **or** forward the results of recent examinations.

Our particular attention goes to patients who are taking anticoagulantia for any reason. The use of this medication needs to be stopped and if needed replaced by subcutaneous heparines. These heparines (fragmin, clexane, fraxiparine) may be administered up to 24 hours before the planned procedure.
6 days: Salicylates: sa: Aspirine, Aspro, Dispril, Asaflow, Acenterine, Cardioaspirine, Aspegic, ...
8 days: Anti-aggregantia: sa: Plavix & Anti- coagulantia: sa: Marcoumar, Marevan, Sintrom

Pre-operative information for the patient

Dear patient, you are scheduled for an operation which will be performed under general or regional anesthesia. The purpose of the included questionnaire is to evaluate your personal condition prior to the operation. It is our intention to assess your health status in order to decide if it will be necessary to do further examinations, these may include blood tests, an electrocardiogram or ECG and a chest X-ray to adjust the anesthetic management to your needs.

Sometimes a sound filled-in questionnaire will suffice as the only pre-operative document. This is the case when you are under 50, when you are in good health, don`t use any medication and the procedure is notified as “minor” or “average” by your surgeon. Your surgeon will inform you on this.

In all other cases the questionnaire should be completed with additional test or recent medical files.

Please be sure to clearly and fully complete this questionnaire, aspecialy concerning the list of all prescribed and over-the-counter medications you are taking. You can do this by yourself but preferably in consultation with you surgeon or general practioner. Your surgeon can prescribe you all necessary tests or can ask you to go to your general practioner. In that case your surgeon will provide all the documents to make it possible for the general practitioner to complete your file.

Pre-operative questionnaire

Surname &First Name: .... **Date of birth:** ....
Age: ....year, **Height**: .... cm, **Weight**: .... Kg
Date of operation: .... **Procedure** ....

Please answer the questionnaire by encircling “YES” or “NO” after the question, check the checkmarks and describe on the dotted line(s) the nature of illness, operation or disorder. List the medication that you currently take in the box at the end of this questionnaire.

Question		
Are you, or did you receive a treatment for a heart disease? …………………………………………………	YES	NO
Do you take heart medication? If “YES” please fill in on the next page ………………………………………	YES	NO
Are you easily short of breath during (any) exercise? ………………………………………………..	YES	NO
Do you sometimes suffer from suffocation or chest pain by exertion? ……………………………..	YES	NO
Do you sometimes suffer from swollen feet or legs? If yes, when? …………………………………	YES	NO
………		
Do you, or were you having a treatment for a vascular disease? ………………………….……………	YES	NO
Do you have varicose veins? ❑ Have you ever had phlebitis? ❑ ……………………………………………	YES	NO
Do you suffer from high blood pressure ❑ low blood pressure ❑ ……………………………………………	YES	NO
Do you take medication for the blood pressure? If “YES” please fill in on the next page ……………….	YES	NO

Question		
Did you ever suffer from major lung disease? (TB, pneumonia) ……………………………………………..	YES	NO
Do you take medication for asthma or hay fever? If “YES” please fill in on the next page ………….……..	YES	NO
Do you take medication for chronic bronchitis? If “YES” please fill in on the next page ……………..….	YES	NO
Do you have a cold or suffer from influenza at this moment? …………………………………………..…..	YES	NO
Are you under treatment for diabetes? If you take medication for it, please fill in on the next page …..….	YES	NO
Have you ever had hepatitis? (Hepatitis A, B, C), or any other liver disease? …………………………....	YES	NO
Are you being treated for a stomach disease? (ulcer, acid) ………………………………………….…...	YES	NO
Do you suffer from a condition of the thyroid? ……………………………………………………….…….	YES	NO
Do you suffer from a kidney disease? ……………………………………………………………….………	YES	NO
Are you being treated for an eye disease? If “YES” please fill in on the next page ……………….……..	YES	NO

Question		
Are you being treated for a nervous system disease? (epilepsy, other?) …………………………….….	YES	NO
Do you take any psychotropic medication? (depression, aggression, lack of concentration?) ……….……	YES	NO

Question		
Were you ever treated for rheumatism, arthrosis? ……………………………………………….……..	YES	NO
Were you ever treated for back or neck pain? What kind of? ………………………………………….	YES	NO
Can you open your mouth wide enough? (put 2 fingers on top of each other between your teeth?) ……..	YES	NO

Question		
Are you obese? = BMI (body mass index) > 30 ………………………………………………………………	YES	NO
BMI: weight in kilograms (kg) divided by the height in meters. Fe: BMI > 30		
Height/weight 1501>68,155/>71, 160/>76, 1651>82, 170/>86, 175/>91, 1801>96, 185/>101, 1901>107		

Question		
Do you smoke? If yes, how many cigarettes a day? ……..... If stopped, how long ago? …………….……	YES	NO
Do you regularly drink alcohol? (how many units/day?) ……….………………………………………..	YES	NO
Do you use other stimulants? Which ones? Frequency? …………………………………………….	YES	NO
Do you wear contact lenses ❑ hearing aid ❑ gel nails ❑ piercings? ❑ …………………	YES	NO
Do you wear dentures ❑ dental implants ❑ have you any loose teeth ❑ …………………	YES	NO
Do you easally suffer from nausea, vomiting, travel sickness? ……………………………………..	YES	NO

Question		
Do you have any relatives with congenital, hereditary syndromes or diseases ……………………………..	YES	NO
If “YES” which ones? ………………………………………………………………………………………………		
Do you suffer from a contagious disease? ………………………………………………………………….	YES	NO
Aids/HIV ❑, Malaria ❑ , Hepatitis ❑, Other? ………………………………………………………………		

Have you had any trouble with excessive or persistent bleeding after injury or tooth extraction? ………… YES NO
Do you take medication to dilute the blood? ………………………………………………………………….. YES NO
If "YES" please fill in here below and respect the remarks about them!!! ……………………………………………………
Have you ever had a blood transfusion? ………………………………………………………………… YES NO
Did you have an allergic reaction on it? ……………………………………………………………… YES NO

Are you allergic to certain substances? ……………………………………………………………….. YES NO
If "YES" please mark below and describe the reaction ……………………………………………………………………
medication ❑ .... plasters ❑ …….. disinfectants ❑ ….…. food ❑ …….. rubber ❑ …….. latex ❑ ……………………….
anesthetics (dentist) ❑ …….. plants, pollen, trees ❑ …….. other ❑ ………………………………………………………..
Which? .... Which reaction? ....
Which? .... Which reaction? ....
Which? .... Which reaction? ....
……

Have you had an operation before? ……………………………………………………………………… YES NO
Which operation? .... When? ....
Which operation? .... When? ....
Which operation? .... When? ....
Which operation? .... When? ....
Did you have problems with the anesthesia? ……………………………………………………..…….. YES NO

For women only: are you pregnant? ❑ /// Is there a possibility you are pregnant? ❑ ……..…………… YES NO

Do you take medicines? ……………………………………………………………………………….. YES NO
Fill in below all medicines, even homeopathics, sleeping pils and pain-killers you take.

Medication name (block letters)	**Why do I use it?**	**How much and which times?**

Do you wish to mention or ask anything of importance? ……………………………………………………….. YES NO
………
………
………

Do you wish to speak to the anesthesiologist before your operation? ……………………………………… YES NO

I have read this questionnaire entirely, understand it, and I declare to have carefully filled in this list

Authenticate: (date) .... **Signature** ……………………………………………………...........

Under here pls name, stamp, signature ev phonenummer of the doctor who:
1: has helped to fill in the questionnaire and/or read it
2: requested the pre-operative examinations

Doctor :.................................. Signature: ....

Stamp

Information concerning the anesthesia, possible complications and anesthesia fees

- You can find all information concerning the anesthesia, side effects and possible complications in a booklet which is available at the ward you will be admittted to.
- However, if you want more information before your admission you can visit the website of the anesthetic department where you can consult and download the files: www.anesthesie-monica.be
- Information about the anesthesia fees and the supplements can also be found in the same booklet and on the website. For detailed price-info or estimated costs you can contact the secretariat of the department of anesthesia. Look below for contactinfo. (Estimated cost can only be made based on the official code or an accurate description of the operation and on room type preference). Via the hospital priceline you can ask for more information on the costs of your admittance at +32 (0)32402725.
- If you will be hospitalised on campus Antwerpen, you can call the secretariat at +32 (0)32402278 for more information or you can attend the pre-operative consultation every day between 4 pm and 6 pm, ***except on Tuesday***, bringing this questionnaire and the results of the examinations you already had with you.
- If you will be hospitalised on campus Deurne you can call the anesthesiologist at +32 (0)33206060 for specific questions or if you want to make an appointment for a pre-operative consultation.

Important indications for the patient

- You bring with you to the hospital the completed questionnaire and the results of the examinations.
- You are not allowed to drink, eat or smoke six hours before any operation scheduled for general or regional anesthesia.
- Leave your jewelry, watch and other valuable objects at home or give them to the nurse for safe keeping. Piercings must be removed.
- False teeth, glasses, hearing aid, contact lenses, hair clips, combs, ... leave them in your room.
- Remove all make-up, even lipstick and nail varnish.
- Do not wear tight clothes.

Informed Consent Anesthesia

Undersigned, ……………………………………………………………………………………………(first name, surname)

•has, besides the verbal informaton given to me by the reffering physician and his/her team, read this brochure, understands it, and I hereby declare to respect all pre- and postoperative guidelines.

•has completed the questionnaire, and conducted all necessary additional examinations.

•agrees that he/she possibly has to stay overnight even though the operation was planned in day care and will be accompanied home after an operation in daycare. He/she will stay in the company of an adult during the first night

•Understands that the operation, because of binding medical reasons, can be postponed (seldom) by the anesthesiologist.

•Is aware that it is forbidden to drive a car, bike or scooter, perform dangerous work (machines, to iron, ...) or take important decisions within 24H after the operation, regardless of the used anesthetic technique.

•Has the following questions concerning the anesthesia and explicitly wishes to speak to the anesthesiologist before the operation.

………
………
………
………

Gives his/her consent for the necessary anesthesia.

Date ……………………………………., Signature ……………………………………………………………………

Accessibility combined department of Anesthesia: www.anesthesie-monica.be

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