

PRE-OPERATIVE MEDICAL ASSESSMENT (ADULT)

Review of Systems: (circle all that apply)

System	Symptoms	Negative
CVS	chest pain, irregular heartbeat, SOB, difficulty breathing at night, swollen legs or feet	<input type="checkbox"/>
Resp	chronic dry cough, coughing up blood, wheezing or night sweats	<input type="checkbox"/>
Neuro	headache, dizziness, fainting, LOC, memory loss	<input type="checkbox"/>
HEENT	double or blurred vision, loss of hearing, nosebleeds, dentures	<input type="checkbox"/>
Heme	bleeding tendency or clotting tendency	<input type="checkbox"/>
GI	nausea, vomiting, diarrhea, black stools, abdominal pain	<input type="checkbox"/>
GU	difficult urination, burning with urination, blood in the urine	<input type="checkbox"/>
Other		<input type="checkbox"/>

Physical Exam

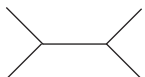
BP _____ HR _____ T _____ RR _____ HT _____ WT _____ Pain Score _____

Check for normal exam, indicate abnormal findings and describe

General	<input type="checkbox"/> A&O x 3 <input type="checkbox"/> NAD
ENT	<input type="checkbox"/> throat clear
Neck	<input type="checkbox"/> no bruits <input type="checkbox"/> no JVD
CV	<input type="checkbox"/> RRR <input type="checkbox"/> no murmurs, rubs, gallops
Lungs	<input type="checkbox"/> CTA bilat. <input type="checkbox"/> no wheezes or rhonchi <input type="checkbox"/> nl resp. effort
Abd	<input type="checkbox"/> soft <input type="checkbox"/> ND/NT
Ext	<input type="checkbox"/> no clubbing, cyanosis, or edema <input type="checkbox"/> nl pulses
Neuro	<input type="checkbox"/> nl and equal strength
Other	

Test	Date	Results
CXR		
EKG		
Echo		
Stress Test		
Cardiac Cath		
Other Studies		

Labs





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Surgery Specific Risk: Low Intermediate High

Severe cardiac conditions: Yes No (Unstable angina, decompensated CHF, significant arrhythmia or significant valvular disease)

Recommendations

RCRI Score: _____ (High-risk surgical procedure, ischemic heart disease, heart failure, CVA/TIA, DM, on Insulin chronic renal insufficiency)

# RCRI Risk Factors	Rate of Cardiac Death, Non-Fatal MI, and Non-Fatal Cardiac Arrest
None	LOW
1 - 2	INTERMEDIATE
3 or more	HIGH

This patient is at Low Intermediate High risk for a cardiac complication

Further testing indicated: Yes No

Further consults indicated: Yes No

Cardiac Recommendation and Medication Management: *(address use of beta-blockers, ACEI, diuretics and statins)* NA

Other Recommendations (list all relevant diagnoses and medications):

1. DM *(address use of insulin and oral DM meds)* NA

2. Pulmonary NA

3. Anticoagulation *(address use of Clopidogrel, ASA, Enoxaparin, etc.)* NA

4. ID *(address antibiotic use)* NA

5. Venous Thromboembolism (VTE) Prophylaxis: NA

6. Other *(address sedatives, NSAIDs, etc.)* NA

Attending Physician Note

PGY/NP/PA Name (printed) _____ Date _____ Time _____

PGY/NP/PA Signature _____ Contact # _____

Attending Signature _____ Date _____ Time _____

I have interviewed and examined the patient. I have confirmed the plan of care with the resident.

Discussed with primary surgical team (name/rank) _____ Date _____ Time _____

Print Name _____

Reviewed by: Attending Surgeon's Signature _____ Date _____ Time _____

Print Name _____

