**Women and Infants’**
**SURGICAL PRE-ADMISSION TESTING NEEDS ASSESSMENT**

**INSTRUCTIONS:**
1. Schedule patient for surgery with OR Booking Office: 401-459-0187 or ext. 60187 from inside WIH. Surgery Date: ______________ Time: ______________

2. If you answer yes to any of the following questions, schedule patient for Pre-Admission Testing with OR Booking Office. 
   ___ Yes: Date: ______________ Time: ____________
   ___ No Pre-Admission Testing required.

3. Complete this form and fax to the Pre-Admission Testing Center: 401-276-7899.

4. The Anesthesiologist may request a pre-operative consult with the Department of Medicine at WIH for your patient.

**SURGERY**
Surgeon: __________________________ Diagnosis: _____________________________________________
Surgical Procedure: ______________________________________________________________
Please check mark: _____ Ambulatory Surgery      _____ Patient to be admitted after surgical procedure

**ANESTHESIA**
Patient desires to meet Anesthesiologist ______  ______
Previous Anesthesia complications ______  ______
(Family) history of malignant hyperthermia ______  ______

**GASTROINTESTINAL**
Liver disease (ie. cirrhosis, jaundice, etc.) ______  ______

**RENAI**
Renal insufficiency/failure ______  ______
Dialysis ______  ______

**ENDOCRINE**
Morbid obesity (BMI > 40 or weight >250 lbs) ______  ______
Diabetes Mellitus with poor glucose control ______  ______
Type 1 Diabetes Mellitus ______  ______
Diabetic keto-acidosis ______  ______
Insulin pump ______  ______
Thyroid mass ______  ______
Hyper or hypo-thyroidism with poor control ______  ______

**MUSCULOSKELETAL**
Disease severely restricting neck movement or mouth opening ______  ______

**HEMATOLOGY**
Bleeding disorders (ie. Von Willebrand’s disease, factor abnormalities, low platelet count, etc.) ______  ______

**PULMONARY**
Oxygen dependent ______  ______
Sleep apnea ______  ______
Activities of daily living limited by shortness of breath ______  ______
DVT/pulmonary embolus ______  ______

**MEDICATIONS**
Warfarin (coumadin) ______  ______
Heparin ______  ______
Enoxaparin (Lovenox) ______  ______
Plavix (Clopidogrel) ______  ______
Ticlopidine (Ticlid) ______  ______

**OTHER**

Surgeon Signature: ________________________________________________       Date: ____/_____/_____

Print Name: ______________________________________________________

6221-003 (2/07, 11/07)