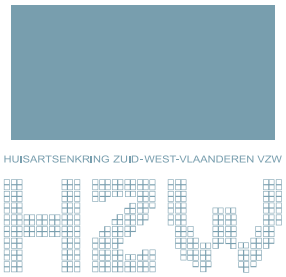
Patient leaflet
for operation or procedure under anaesthesia

PATIENT STICKER

azdelta
Uw ziekenhuis.

This patiënt leaflet is realised in cooperation with the following associations.



Contents of Patient Leaflet:

Dear patient

In this patient leaflet you will find all the information and forms that have to be filled in for your operation or procedure under anaesthetic. This must occur before admission to let that admission run smoothly.

Please complete the patient leaflet on pages 8, 9 and 10 and the medication list on page 11.
About two weeks before the planned procedure, please visit your general practitioner.

If you take **BLOOD THINNERS** or are **ALLERGIC** please inform your doctor.

For further information, or if you have any questions, or if you would like to consult with the anaesthetist beforehand, please contact the admission department or the anaesthetics secretariat.

Admission department

Campus Wilgenstraat
Wilgenstraat 2
8800 Roeselare
051 23 72 55

Campus Brugsesteenweg
Brugsesteenweg 90
8800 Roeselare
051 23 64 64

Campus Menen
Oude Leielaan 6
8930 Menen
056 52 20 32

Campus Rembert Torhout
Sint-Rembertlaan 21
8820 Torhout
050 23 27 46

e-mail: **preopbeleid@azdelta.be**

Anaesthetics department

Campus Roeselare / Menen
Secretariat : 051 23 70 39
E-mail: **secretariaat.anesthesie@azdelta.be**

Campus Rembert Torhout
Admission department
t: 050 23 27 46

To be completed by the ATTENDING PHYSICIAN

PATIENT STICKER

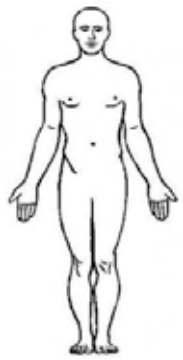
Contact: .....

.....

Tel. no.: .....

CAMPUS:	Wilgenstraat	Brugsesteenweg	Menen	Torhout
TYPE OF ADMISSION:	Hospitalisation	Outpatient surgery	Post-op admission IZ	
PROBABLE DURATION OF STAY:	.....	days		

ADMISSION DATE:	TIME:	DATE OF OPERATION: .....
REASON FOR ADMISSION:	ELECTIVE	(SEMI) URGENT
.....		



Right **Left**

Operation side:				
Right	Left	N/A		
Proposed anaesthesia:				
Local	Plexus	Epidural/Spinal	Sedation	General
Blood type:				
Determination of the blood type and indirect Coombs (in AZ Delta)				

KNOWN ALLERGIES: .....

COAGULATION POLICY	In case of consultation: name of doctor: Dr.		
Medication:	Last taken:	Replaced by:	until:
Medication:	Last taken:	Replaced by:	until:

ANY OTHER MEDICATION TO BE STOPPED: .....

To be completed by the ATTENDING PHYSICIAN

TYPE OF PROCEDURE (PLEASE CIRCLE)

minor	intermediary	major
E.g.: Removal of skin lesion, Bartholin gland Drainage chest abscess Carpal tunnel Septumplasty Hydrocoele Cataract Etc.	E.g.: Varices (adeno) tonsillectomy Knee arthroscopy Tympanoplasty Section Lap cholecystectomy Etc.	E.g.: abdominal hysterectomy Joint prothesis (THP, TKP) TUR Prostate Neurosurgery Thyroidectomy Nephrectomy Jugular gland extirpation Major abdominal surgery, etc.

N.B.: IF > 70 YEARS OLD: AT LEAST ASA II

	ASA I	ASA II	ASA III	ASA IV
ASA-classification.	Normal healthy patient	Patient with mild systemic disease	Patient with debilitating systemic disease, that limits normal activity	Patient with debilitating systemic disease, constant threat to life.
	E.g.: Patient with good exercise capacity	E.g.: good treated hypertension, good regulated diabetes, mild obesity, anaemia, slight chronic bronchitis.	E.g.: seriously disrupted hypertension - uncontrolled or disrupted diabetes - moderate angina pectoris, initial cor decompensation	E.g.: angor pectoris when resting - pulmonary insufficiency - kidney insufficiency - cardiac insufficiency - liver insufficiency
Minor procedure	Anamnesis + Clinical evaluation ECG > age 65 Lab if indicated	Idem ASA I + Lab if indicated	Anamnesis + clinical evaluation + Lab + ECG	
Intermediary procedure				
Major procedure	Anamnesis + clinical evaluation Lab + ECG > age 65			

GUIDELINES

☐ **Lab** BG + indirect Coombs: on / /20 (AZ Delta): ☐ **ECG** if indicated: e.g. RX-Thorax, etc.

☐ **Consultation GP** ..... Date: .....

☐ **Consultation cardio, pneumo, nephro, endocrino:** ..... Date: .....

☐ **Consultation anaesthesist** ..... Date: .....

☐ **Pacemaker**	NO	YES	advice on pre-op adjustment of PM
☐ **Defibrillator**	NO	YES	advice by cardiologist
☐ **Neurostimulator present**	NO	YES	bring control device
☐ **Deep Brain Stimulator**	NO	YES	advice neurosurgery
☐ **Subcutaneous insuline pump**	NO	YES	inform the diabetes nurse

GUIDELINES FOR NURSING WARD

☐ **Preop lab** Controle Type and Screen ..... order PC:.....E Blpl:.....

☐ **Prevention contrast nephropathy**	NO	YES	.....
☐ **Endocarditis prophylaxis**	NO	YES	.....
☐ **Anaphylaxis prophylaxis**	NO	YES	.....
☐ **Bowel preparation**	NO	YES	.....
☐ **PM and/or defibrillator check**	NO	YES	.....

☐ **OTHER** e.g. antidecubitus mattress .....

To be completed by PATIENT and ATTENDING PHYSICIAN

REQUIRED CONSENT BY THE PATIENT ON THE BASIS OF INFORMATION ABOUT THE OPERATION/TREATMENT/EXAMINATION

Dr. ..... **. has informed me on** ...../...../ **20**.....

about the following operation/treatment/examination .....

.....

on ...../...../ **20**..... **on the campus of** **Wilgenstraat / Brugsesteenweg / Menen / Torhout**

The doctor has given me more explanation about:
- the health situation and diagnoses and which operation/treatment/examination will be carried out;
- the reason, duration, urgency, nature, goal and frequency of the operation/treatment/examination;
- the chances of success;
- the pros and cons, possible complications and side effects during the procedure and/or recovery period;
- the precautions to be taken inc. necessary examinations before and after the operation/treatment/examination;
- the possible alternatives and the chances of recovery with and without the procedure;
- the cost price and the personal share to be paid as a patient.

I know that I can always ask the doctor any questions. If you have any questions regarding the invoice, please ask the finance department. (factuur@azdelta.be or 051 23 70 54).

I will closely follow the instructions of my doctor to let the operation/treatment/examination and recovery go as favourably as possible. I know that despite the greatest precautions, the doctors and nursing team cannot guarantee absolute success.

I agree that the doctor can carry out additional medical actions – in connection with the original reasons for treatment – that are necessary to recover or to maintain my state of health.

I confirm my consent to the doctor who signs below to carry out the operation/treatment/examination together with another doctor or doctors in training. In exceptional circumstances, the doctor that I have chosen may be replaced by a colleague. I agree that sometimes external operators may be present during the procedure (e.g. representatives of prothesis equipment, necessary for the procedure, physical therapists, trainee doctors, trainee nurses, etc.).

I can revise my opinion at any time and decide not to let the procedure go ahead. To this end I will contact the doctor who is treating me.

I give my consent for recording anonymous, photographic data and possibly use it for educational purposes and/or scientific publications.

Drawn up in Menen / Roeselare / Torhout

on ...../...../20.....at.....am/pm

Patient or legal representative
First name and surname + signature + 'Read and approved'

Attending physician
Signature and stamp

To be completed by PATIENT and ANAESTHETIST

CONSENT FOR THE ANAESTHESIA AND ANALGESIA (PAIN RELIEF) AND BLOOD TRANSFUSION:

I know that a general anaesthesia and/or local anaesthesia and pain relief is required for the planned operation or procedure. I give my permission for this to a recognised anaesthetist who will sign this document with me.

I have read the leaflet "Anaesthesia in children: information leaflet for parents and children" carefully. If I have any questions, I can turn to the Anaesthetics department for consultation and further explanation.

I understand that general anaesthesia and pain relief are accompanied by risks. I realise that the risks can be far greater if I do not follow the guidelines stated in the leaflet. The risks can also be far greater, depending on my medical condition.

I furthermore declare that I agree to any further admission to the hospital if this is necessary.

I will fast before the operation. (Read in the guidelines in the information leaflet: admission in hospital)
On the morning of the operation or procedure, I will take my medication with a little water unless the attending physician prescribes to the contrary, think especially of all blood thinners).

I will not drink any alcohol up to 24 hours after the procedure.

I will not leave the hospital unattended. For the first 24 hours after the procedure, I may not drive a car or ride a motorbike, scooter or bicycle and I may not operate machines. I will not sign any important documents and I will not take any important decisions.
There will be someone at home for the first 24 hours after the operation.

I know that the anaesthetist cannot guarantee the result of the anaesthesia and/or pain relief. I understand and know that the type of anaesthesia and/or pain relief may be changed without my knowledge if this is necessary.

I hereby declare that, if necessary, I may be administered blood products.
(If you do not agree, delete this sentence and confirm in writing on the dotted line below that no blood products may be administered to you, followed by your signature + attest)

Name: .....

Reason: .....

Drawn up in Menen / Roeselare / Torhout

on ...../...../20.....at.....am/pm

Patient or legal representative
First name and surname + signature + 'Read and approved'

Attending physician
Signature and stamp

To be completed by PATIENT

AGE:	LENGTH:	WEIGHT:

ALLERGY: Yes / No / I don't know .....

If so: to what product? E.g. latex, medication (e.g. antibiotics), banana or kiwi, iodine (disinfectant or contrast medium), or other : .....

Which reaction occurred? E.g.: severe vomiting, skin rash, thick lips, respiratory problems, shock? .....

Please note: When taking antibiotics: only diarrhoea or a yeast infection is a side effect, not an allergy.

PACEMAKER / DEFIBRILLATOR	NEUROSTIMULATOR	DEEP BRAIN STIMULATOR

Have you previously been operated on with a general or local anaesthesia? If so, in what year or at what age, and what operation or treatment?	**Yes / No**
Have you previously been treated by GP or admitted to hospital for diseases or medical conditions? If so, in what year or at what age and for which conditions?	**Yes / No**
Did you have an unusual reaction to previous anaesthesia? If so, please describe the reaction very clearly.	**Yes / No**
Has a family member ever had problems with anaesthesia? If so, please describe accurately:	**Yes / No**

To be completed by PATIENT

Do you smoke? If so, how many cigarettes ...../ day? How long have you been smoking?	**Yes / No**
Do you drink alcohol? If so, how many glasses ...../ day or...../ week.	**Yes / No**
How often do you drink 6 (women) / 8 (men) or more glasses of alcohol per occasion? O never O less than once a month O monthly O weekly O daily	
Do you use drugs, narcotics or stimulants? Which ones?	**Yes / No**
For women: could you be pregnant?	**Yes / No**
Have you had heart problems, heart murmur, arrhythmias, pain in the chest, a stent or blowing through? If so, please describe:	**Yes / No**
Is your blood pressure too high or too low? What is your normal blood pressure? ..... /	**Yes / No**
In the past year, have you fainted or become unwell? If so, please describe:	**Yes / No**
Are you easily out of breath and is there pressure on your chest in case of exercise? If so, please describe:	**Yes / No**
Do you have respiratory disorders, asthma or chronic bronchitis? If so, please describe:	**Yes / No**
Do you use a CPAP device at night? If so, please bring it with you.	**Yes / No**
Are you out of breath when resting or lying down?	**Yes / No**
Do you have varicose veins?	**Yes / No**
Have you ever had a phlebitis /a blood clot in your leg? Have you ever had a pulmonary embolism (blood clot in the lungs)?	**Yes / No** **Yes / No**
Do you have coagulation problems? Do you continue to bleed for a long time after a wound, nose bleed or tooth extraction?	**Yes / No**
Are you being treated by a haematologist?	**Yes / No**
Have blood products been administered in the past? If so, did any problems occur?	**Yes / No**

To be completed by PATIENT

Do you or have you ever had a kidney problem? ……	**Yes / No**
Do you have or have you ever had liver problems e.g. hepatitis, etc.)? If so, please describe: …… ……	**Yes / No**
Have you ever had a stomach ulcer?	**Yes / No**
Have you ever had a hiatus hernia?	**Yes / No**
Do you have thyroid problems?	**Yes / No**
Are you being treated for diabetes? If so, in case of insulin: please bring your glucometer and insulin pen(s) with you.	**Yes / No**
Have you had a cold recently? Have you had the flue in the past months? Did you have a fever?	**Yes / No**
Are you HIV positive (seropositive)? Are you MRSA positive (hospital bacteria) or have you had it? Other infections? ……	**Yes / No** **Yes / No**
Do you use cortisone or have you had a cortisone injection in the past 6 months?	**Yes / No**
Do you or a relative have a muscle disease? If so, please describe:…… ……	**Yes / No**
Do you have back problems?	**Yes / No**
Do you have neck problems?	**Yes / No**
Do you have trouble opening your mouth?	**Yes / No**
Do you have a neurological disease? (Paralysis or loss of strength, Parkinson, epilepsy, brain haemorrhage, stroke, multiple sclerosis, ...) If so, please describe: ……	**Yes / No**
Do you suffer from an illness not named here? Please describe: …… ……	**Yes / No**
Do you have dentures (removable or not), loose teeth, a prothesis or braces, a dental implant?	**Yes / No**
Do you wear glasses, contact lenses or a hearing aid?	**Yes / No**

To be completed by PATIENT: HOME MEDICATION LIST

OVERVIEW OF HOME MEDICATION:
PLEASE COMPLETE CLEARLY AND CORRECTLY OR COPY.
BRING ALL THE MEDICATION IN THE ORIGINAL PACKAGING WITH YOU IN THE HOSPITAL'S MEDICINE BAG.

MEDICINE			ADMINISTRATION TIME + NUMBER				REMARK
Name	Dose	form	08:00	12:00	18:00	22:00	
Ex.: Dafalgan forte	1 gram	1 tablet	ex. 1				In case of pain
Ex.: Zocor	40 mg	1 tablet	ex. 1				

Do not forget:
- hormonal preparations (e.g. contraceptive pill)
- sleep medication
- ointments
- painkillers
- injections pens
- puffers
- food supplements
- homeopathy
- cortisone
- medicinal herbs
- eye drops
- something for an upset stomach
- medication patches

Diabetes patients:
- bring glucose meter
- bring insulin

To be completed by the GP

STOP MEDICATION BEFORE PROCEDURE.
ANTI-COAGULATION MEDICATION: (GUIDELINES WEBSITE AZ DELTA)

COAGULATION POLICY	In case of consultation: name of doctor: Dr. ……..		
Medication:	Last taken:	Replaced by:	until:
Medication:	Last taken:	Replaced by:	until:

OTHER MEDICATION: (INFO P. 14)

MEDICATION	DATE STOPPED

To be completed by the GP

Dear colleague

A proper pre-op policy and procedure has various advantages, such as for example a reduction in perioperative morbidity, higher patient satisfaction, better safety, more efficient planning, etc. That is why we are counting on your support. Exams less than 6 months old do not have to be repeated, unless the clinical condition has recently changed.

ANAMNESIS

(important information not named in the questionnaire):

.....

.....

.....

CLINICAL RESEARCH

CARDIAC: **Blood pressure:** ..... **/**..... **mmHg, Heart rate:**..... **/min.**

.....

.....

VASCULAR:

.....

.....

RESPIRATORY:

.....

.....

GASTRO-INTESTINAL:

.....

.....

UROGENITAL:

.....

.....

NEUROLOGICAL/LOCOMOTIVE:

.....

.....

INFECTIOUS (MRSA, OTHER?)

.....

.....

OTHER:

.....

To be completed by the GP

TECHNICAL EXAMINATIONS (see guidelines on page 5)

ECG-protocol: ……
(please add the ECG itself or a copy)

MRSA-screening done by: ○AZ Delta ○GP ……/……/ 20……..

LAB add protocol or mail the results to **preopbeleid@azdelta.be** (or complete below)

Date blood drawn: ……/……/ 20…… (lab:……)

Hgb	Hct	RBC	Blpl	WBC
PT	INR	aPTT		
Creat	Ureum	GFR	Glyc	HBa1c(diabetes)
Na	K	Cl	Bic	TSH
AST	ALT	gamma-GT	AF	Bil

OTHER TECHNICAL EXAMINATIONS: e.g.: RX thorax: only if clinical indication

REMARKS by the **GP** for the **SPECIALIST** and/or**NURSES** on the **WARD**:

……..
……..
……..

GP's stamp Signature Date……/……/20……

If you have any other medical questions relating to the pre-op policy, please mail to:

preopbeleid@azdelta.be

GP / Medication policy

Please continue administering most chronic home medication, also on the morning of the day of the operation!

N.B..: continue administering anti-arrhythmic agents, in case of ablation seek advice from cardiologist.

MEDICATION THAT MUSTS BE STOPPED BEFORE ADMISSION!

Take the last time THE DAY BEFORE ADMISSION	
DIURETICS	
ACE inhibitors, SARTANS	exceptions: chronic heart failure and greatly reduced ventricular function (EF<30%): continue on same day
ORAL ANTIDIABETICS/INCRETIN-MIMETICs	exceptions: metformin or combined preparation with metformin: take last time 48 hours before surgery
If insulin therapy: admission at 08:00	admission at 08:00: insert drip containing glucose + administer half dose of insulin - bring insulin pens and glucose meter with you
MEDICATION for the CENTRAL NERVOUS SYSTEM: TCA, SSRIS, lithium (Camcolit®, Maniprex®), antipsychotics, neuroleptics, etc.	
MAO INHIBITORS: Moclobemide®, Selegiline (Eldepryl®)	N.B.: Eldepryl®(to treat Parkinson): half dose on the morning itself exception: fenelzine (Nardelzine®): stop 3 weeks in advance
THEOFYLLINE: Xanthium®	
ANION EXCHANGERS: Questran®, Colestid®	
FIBRATES: Ciprofibraat®, Hyperlipen®, Fenofibraat®, Lipanthyl®, Lipanthylnano®, etc.	myopathy, rhabdomyolysis, renal insufficiency
NSAIDs (preoperative maintenance therapy)	exception: long-acting NSAIDs (Arcoxia®, Feldene®, Brexine®, Meloxicam®, Naproxen®, Piroxicam®, etc.): stop ≥ 3 days in advance pain control permitting
Medication that must be stopped longer in advance	
ANTI-COAGULATION POLICY	cfr. guidelines website AZ Delta or advice physician
METFORMIN or combined preparation with metformin	take last time 48 hours before surgery (lactic acidosis and renal failure)
MAO INHIBITOR: fenelzine (Nardelzine®)	stop 3 weeks in advance (if necessary consult with psychiatrist)
FOOD SUPPLEMENTS: St John's Wort, valerian, vitamin E, ginkgo Biloba, garlic, ginseng, red rice, etc.	stop ≥7 days in advance
IMMUNOMODULATORS: Arava®, Humira®, Ledertrexate®, etc.	stop 2 weeks in advance if possible (risk of infection and delayed wound healing)

AZ Delta and the doctors cannot be held liable for complications arising from the use of the guidelines in this leaflet.

Checklist nursing ward

Patient info checked? (name, date of birth, ID bracelet on) Yes / No

Patient leaflet: complete? (for example, Informed consent completed?) Yes / No

ALLERGY? No / Unknown / Yes: .....

INFECTION .....

FASTING POLICY

Last drank: what ..... time: .....

Solid food: until ..... time: .....

PRE-OP GUIDELINES

Transfer note read? And assignment carried out?

Guidelines in connection with PM / defibrillator / neurostimulator observed?

T & S completed? N/A NO YES

PC present in lab: NO YES

Anti-coagulants: STOPPED? N/A NO YES

since: ..... which ones: .....

replaced by: .....

GENERAL

Patient prepared: glasses, lenses, hearing aid, surgical gown, clean bed linen, jewellery, bracelets .....

Necessary equipment given? e.g. abdominal band, stockings, control device for neurostimulator, puffers, ...

Area of operation prepared? .....

Urinated before departure? **(N.B.: not in case of patient urology Hexvix)**

Sufficient labels? .....

Antidecubitus mattress? .....

General remarks: e.g.: scared, confused, dementia

General remarks: language, hard of hearing, visually impaired, others,

.....

PARAMETERS

Blood pressure	Pulse rate	Temperature	SpO2	Pain
mmHg	/min	°	%	/10

Glycemia: (if diabetes patient) mg/ml	Insulin administered?

Pre-op medication administered? ○ Yes..... ○ No, Because:.....
Department:..... **Name of nurse:**.....

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