Mackenzie Health

Patient's OR Date: _____
dd/mm/yyyy

Pre-admission Packages

Mackenzie Health
OR Scheduling
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

Surgery Preparation Package

Please complete this paper package with your patient and upload into EPIC.

In EPIC please complete the following:

- Case request for surgical procedure
- Placement on the snapboard in your assigned day
- Pre-admit appointment request if required
- Completion of Surgical Pre-op Note as well as History and Physical (if surgeon completing)
- Orders for Pre-admission Testing and Day of Surgery

Reminders

- Wait Times data is entered into EPIC
- Complete charts must be submitted in EPIC 72 hours in advance of the day of surgery

If you have questions, please contact OR Scheduling at 905-883-1212 Ext. 2001.

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CONSENT TO TREATMENT, OPERATIVE PROCEDURE OR INVESTIGATION

Treatment/Operation/Test: *(Do not use abbreviations – write out in full)* _____

_____

I consent to the proposed operative procedure(s), treatment(s) or test(s) described above.

I confirm that the anticipated nature, benefits, risks and side effects of the above have been explained to me, including the anticipated nature, benefits, risks and side effects of any alternative course(s) of action and likely consequences of not having the treatment/operation/test. I understand that other qualified individuals may assist in the treatment/operation/test, this may include qualified medical learners. Any questions I have asked have been answered to my satisfaction.

Signature of Patient/SDM	PRINT NAME	Date (dd/mm/yyyy)

If signed by SDM, state of relationship to patient

If patient is a U.S. or foreign resident, please complete Jurisdiction of Medical Liability Waiver on the reverse of this form

I have read/interpreted/communicated the above consent to treatment information for the patient/SDM.

Signature of Interpreter (if required)	PRINT INTERPRETER'S NAME

TELEPHONE CONSENT

I confirm that I have explained by telephone to _____ the nature of
Name of Substitute Decision Maker

the stated treatment(s), operative procedure(s), or test(s), the anticipated benefits, material risks, material side effects, any alternative course(s) of action and the likely consequences of not having the treatment/operation/test and have answered all their questions.

Signature of Physician/Proposer of Treatment	PRINT NAME/NAME STAMP	Date (dd/mm/yyyy)
Signature of 3rd Party of Telephone Consent	PRINT NAME	Date (dd/mm/yyyy)

EMERGENCY TREATMENT WITHOUT CONSENT

I am proceeding with the emergency treatment(s) as stated on the reverse of this consent because the patient meets the Conditions for Emergency Treatment without Consent as outlined in **Mackenzie Health's Consent to Treatment Policy** and the **Health Care Consent Act.**

Signature of Physician/Proposer of Treatment	PRINT NAME/NAME STAMP	Date (dd/mm/yyyy)

TO BE COMPLETED BY THE HEALTH PRACTITIONER PROPOSING THE TREATMENT

(N.B. Failure to complete this section of the consent form may result in the withholding of treatment to this patient.)

I confirm that I have explained the nature of the above operative procedure(s), treatment(s) or test(s), the anticipated benefits, material risks, material side effects, any alternative course(s) of action and likely consequences of not having the treatment(s) to the above patient / substitute decision maker and answered all their questions.

Signature of Physician/Proposer of Treatment	PRINT NAME/NAME STAMP	Date (dd/mm/yyyy)

CONSENT TO TREATMENT, OPERATIVE PROCEDURE OR INVESTIGATION (Continued)

JURISDICTION OF MEDICAL LIABILITY WAIVER FOR TREATMENT OF U.S. AND OTHER FOREIGN RESIDENTS

I agree that the relationship between myself and Mackenzie Health, its staff, delegates, physicians and other independent health care practitioners providing medical or other health care and treatment to me shall be governed by and construed in accordance with the laws of the Province of Ontario. I acknowledge that the Courts of the Province of Ontario shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action. I hereby agree that I will commence any such legal proceedings in the Province of Ontario and I hereby submit to the exclusive jurisdiction of the Ontario Courts.

Signature of Patient/SDM | PRINT NAME | Date (dd/mm/yyyy)

I have read/interpreted/communicated the above information regarding the Jurisdiction of Medical Liability Waiver to the patient/SDM.

Signature of Interpreter (if required) | PRINT INTERPRETER'S NAME

BLOOD TRANSFUSION/MANUFACTURED BLOOD PRODUCTS

☐ NOT APPLICABLE

☐ **Electronic blood consent obtained for this encounter**

I consent to receive donor blood and/or blood products manufactured from donor blood.
I acknowledge that the benefits and risks of receiving a donated unit of blood, including blood products manufactured from donor blood, have been discussed with me and all questions have been answered to my satisfaction. I have received the "Patient Information on Transfusion" brochure.

Signature of Patient/SDM | PRINT NAME | Date (dd/mm/yyyy)

If signed by SDM, state relationship to patient

I have read/interpreted/communicated the above information regarding blood and blood products to the patient/SDM.

Signature of Interpreter (if required) | PRINT INTERPRETER'S NAME

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ADMISSION HISTORY AND PHYSICAL

CHIEF COMPLAINT

H.P.I.

PAST HISTORY

FAMILY HISTORY

MEDICATIONS

F. INQ.

ALLERGIES

PHYSICAL EXAMINATION

APPEARANCE	**WT.**	**TEMP.**	**PULSE**	**B.P.**
HEAD AND NECK				
E.N.T.				
CHEST				
BREAST/AXILLAE				
C-V				
ABDOMEN				
G-U				
RECTAL				
BACK AND EXTREMETIES				
C.N.S.				
SKIN				

OTHER:

DIAGNOSIS:

PLAN:

5022

Date: _____ _____ M.D.
dd/mm/yyyy Physician's Signature

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Information to be Completed by Patient

(Please give the following pages to your patient)

Contents:

Please Print

SURNAME/LAST NAME/FAMILY NAMES		GIVEN NAME/FIRST NAME	
PREVIOUS NAME (EG. MAIDEN NAME/MARRIED NAMES)	RELIGION	DATE OF BIRTH YEAR MONTH DAY	SEX ☐ FEMALE ☐ MALE
APT.# STREET ADDRESS	CITY	PROVINCE	POSTAL CODE
PHONE NUMBERS HOME BUSINESS	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ COMMON-LAW		
1ST EMERGENCY NOTIFICATION		RELATIONSHIP	
ADDRESS		HOME NUMBER	BUSINESS PHONE NUMBER
2ND EMERGENCY NOTIFICATION		RELATIONSHIP	
ADDRESS		HOME NUMBER	BUSINESS PHONE NUMBER
FAMILY DOCTOR ADDRESS			PHONE NUMBER
HEALTH CARD NUMBER	VERSION CODE (if applicable)	NAME AS SHOWN ON HEALTHCARD	HEALTH INSURANCE CARD EXPIRY DATE (yyyy/mm/dd)
☐ OTHER PROVINCIAL HEALTH INSURANCE			

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Health Card Number:

Date of Birth:

Preoperative Anaesthetic Questionnaire

Part I – For all Surgery Programs Patients
To be completed by patient or family member

Date: _____(dd/mm/yyyy)

Name: _____

Height: _____ cm ☐ ft/in ☐ **Weight:** _____ kg ☐ lb ☐

Languages Spoken: _____

Do you need an interpreter to communicate with your care providers? Yes ☐ No ☐

1.) List of all operations during which you were given a general or other type of anaesthetic:

a) Within one year _____

b) Over one year _____

_____

2.) Do you or have you been told if you have any of the following? Please answer all questions below.

Anesthesia History	Yes	No	Comments
Provider told you that you are hard to intubate			
Nausea and vomiting following sedation			
Malignant hyperthermia			
Headaches after an epidural or spinal anesthesia treatment			
Remained aware of your surroundings once you were sedated			
Pseudocholinesterase deficiency or succinylcholine sensitivity			
Delayed awakening from anesthesia			
Motion sickness			
Sleep apnea			
Have you ever had a reaction to a local/general anaesthetic? Please describe the reaction.			
Has anyone in your family had a reaction to a local/general anaesthetic? Please describe the reaction they had.			
Is there anything else that you would like to tell your anaesthesiologist?			

3) Do you have any drug allergies: Yes ☐ No ☐ **If yes, please fill in the information below.**

Drugs	Type of Reaction	Drugs	Type of Reaction

4.) Are you allergic to LATEX? Yes ☐ No ☐ Don't know ☐ **(nurse to confirm)**

5.) List of any other non-drug allergies (e.g. Grass, Pollen) _____

6.) List of your medications including nonprescription or herbal remedies:

Medication	How much are you taking	How often?	Last Taken (date/time)	

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Patient label

Preoperative Anaesthetic Questionnaire

7.) Are you on blood-thinning medications (prescribed or natural)? If yes, please indicate which medications.
Yes ☐ No ☐ (If yes, list the medication and state when stopped) _____

8.) Do you smoke or have you ever smoked? Yes ☐ No ☐
If yes, state amount of cigarettes/cigar you smoke per day _____ and for how many years _____
If you stopped, when? _____

9.) Have you ever, or do you currently use nicotine e-cigarettes? Note that cannabinoid vaping will be asked in the Marijuana/Cannabinoids section. Yes ☐ No ☐

- How often are you using e-cigarettes? (i.e. daily ☐ weekly ☐) _____
- How many times do you refill your vape per week? _____
- What type of substances do you use? (i.e. Nicotine ☐ Flavour ☐) _____
- If you stopped, when? _____

10.) Do you use any recreational drugs? Yes ☐ No ☐

- Have you ever, or do you currently use marijuana or cannabinoids? Yes ☐ No ☐
- How often are you using marijuanna/cannabinoids? _____
- What method(s) do you use? _____
- What substances do you use? THC ☐ CBD ☐
- If you use any other substances, please state them. (i.e. cocaine, heroin, fentanyl) _____
- Describe, on average, how much you use weekly? _____

Comments _____

11.) Do you or did you drink alcohol/beer daily? Yes ☐ No ☐ If yes, state the amount per day _____
If you stopped, when? _____

12.) Do you have any loose, capped or false teeth? If yes, check which and state which tooth (teeth)
loose ☐ capped ☐ false teeth ☐ Other ☐ _____

13.) Have you ever been diagnosed with any of the following condition?
********Please answer every question listed below.***

Condition	Yes	No	Don't know	Comments (for example when were you diagnosed)
Chronic bronchitis				
Pneumonia				
Shortness of breath				
Asthma				
COPD/Emphysema				
Any other conditions that affect your breathing?				
Frequent headaches				
Migraines				
Dizziness				
Stroke				Residual deficits? Yes ☐ No ☐
Seizures				How often? _____
Anxiety				
Any other conditions that affect your nervous system?				
Chronic back pain				
Chronic neck pain				
Arthritis				
Temporomandibular Joint Syndrome (TMJ)				
Any other conditions that affect your bones?				
Any other conditions that affect your muscles?				
Anemia				
Thalassemia				

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Patient label

Preoperative Anaesthetic Questionnaire

Condition	Yes	No	Don't know	Comments (for example when were you diagnosed)
Thalassemia				
Sickle cell				Disease ☐ Carrier ☐
Chest pain (angina)				
High blood pressure				
Heart disease				
Heart attack				
Heart Failure				
Irregular heart beat				
Heart murmur				
Do you have a pacemaker?				
Blood clot				Leg ☐ Long ☐
Blood clot in lungs				
Bleeding tendency				
Past blood transfusion?				If so, any reaction? Yes ☐ No ☐
Hiatal hernia				
Peptic ulcer				
Heart burn/acid reflux/GERD				
Crohn's / Colitis/ IBS				
Hepatitis				A ☐ B ☐ C ☐
Liver problems				
Diabetes				Insulin ☐ Pill ☐ Diet ☐
Thyroid condition				
Kidney failure				
Dialysis treatment				Hemodialysis ☐ Peritoneal Dialysis ☐
Any other conditions that affect your bladder?				
Any other conditions that affect your kidneys?				
HIV/AIDS				
Tuberculosis				
Cancer – Where? _____				Chemotherapy ☐ Radiation ☐
Are you pregnant?				How many weeks? _____
Other				

14.) Are you currently being cared for by any specialists? (i.e., endocrinologist, cardiologist, etc.). If yes, please state the specialist's name, specialty and contact information.

Specialist Name:_____ Specialty: _____ Telephone: _____

Specialist Name:_____ Specialty: _____ Telephone: _____

Specialist Name:_____ Specialty: _____ Telephone: _____

15.) Have you ever been on Isolation precautions when in hospital? Yes ☐ No ☐ If yes, when _____

What were the infections? (i.e., MRSA, VRE)_____

16.) If your life is in danger because of severe blood loss, will you accept a transfusion of blood, its components or products? Yes ☐ No ☐

If the answer is "No", please tell your surgeon <u>before</u> the day of surgery.

17.) If you are having surgery today, please state <u>what time</u> you <u>last</u> ate any food or drank any fluids, including water?

Food: Time _____ Date_____(dd/mm/yyyy) **Drink:** Time _____ Date: _____(dd/mm/yyyy)

18.) Has someone assisted with completing with this form? Yes ☐ No ☐

Name: _____ Telephone Number: _____

(Name of person completing the form)

Signed: _____ Date: _____ Relationship to patient: _____

(Signature of person completing the form) (dd/mm/yyyy) (if applicable)

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DAY SURGERY HOME ESCORT RESPONSIBILITY FORM

Contact Person: _____

Telephone: _____

Waiting in waiting area

☐ Yes ☐ No If no, Location _____

Home Support on Discharge

☐ N/A ☐ Yes ☐ No If no, contact CCAC

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

Statement of Responsibility

I understand that it is my responsibility not to operate a motor vehicle for 24 hours following this procedure and to have a responsible adult accompany me to my home.

_____ _____

Witness Signature of Patient or Designate

_____

Date (dd/mm/yyyy)

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PATIENT INFORMATION ON TRANSFUSIONS

This information is provided for patients who may need a transfusion of blood or blood products. It contains answers to common questions about blood and transfusions.

IS IT SAFE?

Receiving blood is safer today than ever. Careful questioning is used to select donors and the most up to date scientific methods are used to test donated blood for viruses and diseases. These safety measures have lowered the chance of disease transmission. Recent numbers show the chance of getting HIV from a transfusion is 1 in 2.15 million. For Hepatitis B, the chance is 1 in 125,000 and for Hepatitis C it is 1 in 935,000. Further risks that your doctor can discuss, occur with a total rate of 1 in 5,000. These risks are small compared to the potential benefits of getting a blood product. For comparison, the chance of dying in an automobile accident is 1 in 10,000.

All blood is also tested for West Nile Virus. Canadian Blood Services also screen donors who might be at risk of transmitting variant Creutzfedt-Jakob Disease.

WHAT IS BLOOD?

Blood has three main parts. These are red blood cells, platelets and the liquid part called plasma. These are usually made into separate blood products. Blood is needed for the human body to function properly. Red blood cells carry oxygen. Red cell products are used for patients who have lost blood due to an accident or major surgery, or for patients who have an illness that lowers the number of their own red blood cells (anemia). Platelets help in blood clotting and wound healing. Platelets are used when a patient is bleeding and their platelet count is low or if they are not working properly. Plasma is the clear liquid part of blood, which holds the red blood cells and platelets. Plasma has many proteins and factors needed to form a clot. Plasma is most often given to patients with serious clotting problems.

WHY DO I NEED A TRANSFUSION?

Transfusions are used to treat an illness/or condition. The type of illness will determine what type of blood product is used since different parts of the blood do different things in the body.

HOW ARE BLOOD PRODUCTS TRANSFUSED?

Most blood products are given into a vein (intravenous) and some are given into the muscle (injection). Transfusions can take up to 4 hours depending on the patient and the product being transfused.

WHAT ARE SOME PROBLEMS THAT MAY OCCUR WITH TRANSFUSION?

- Minor and temporary reactions occur in about 1 in 100 people. These reactions include fever, chills or rash during or shortly after transfusion.
- All blood is tested for infectious diseases, but there is still a very small risk of disease transmission. Bruising or swelling might occur where the needle is put into your vein.
- Some patient may form antibodies following a transfusion. This is called allo-immunization. This has no symptoms and does not put your health in danger. In this case, you will need extra testing before you have blood transfusions in future.

WHAT ARE THE ALTERNATIVES TO TRANSFUSION?

For certain surgeries we can sometimes use other treatments. When you meet with your doctor, ask him or her if an alternate is available to you.

Alternatives to transfusion include:

- In some cases a starch solution (Pentaspan) can be used instead of plasma
- Salvaging of blood during surgery is another option but it is not available at Mackenzie Health.
- No transfusion is also a choice. There may be a risk to your health if you do not receive a transfusion. This should be discussed with your doctor.

WHAT ARE THE ADVANTAGES OF A TRANSFUSION?

Transfusions do save lives. They help you to feel better and improve your quality of life. We give blood regularly in health care. Blood transfusions help us to do major surgery and other medical treatments safely for patients.

WHAT ARE THE RISKS OF NOT HAVING A TRANSFUSION?

If you don't have enough red blood cells, parts of your body might not get enough oxygen. Lack of oxygen can permanently damage vital organs such as your heart or brain. A transfusion might be necessary to prevent the damage to your body.

Jewelry and Body Piercing Removal for Surgery

What type of body jewelry needs to be removed before surgery?

All rings-including wedding rings	Necklaces	Bangles
Toe rings	Barbells	Labrets
Earrings	Watches	Captive bead rings
Chains	Spacers	Religious/sacred medal objects

Why do I need to remove body jewelry before surgery?

- To prevent burns from equipment
- In the event of swelling of fingers and toes (surgery involving arms or legs)
- To avoid choking or other injuries from mouth jewelry
- To avoid infection at the piercing site
- To avoid tearing or injuring the area near the jewelry
- To avoid loss of jewelry or precious stones
- To reduce the risk of injury to hospital staff

What if I cannot remove my body jewelry before surgery?

Your jewelry must come off before you come to the hospital. For assistance, please go to a jeweler as this can prevent unnecessary damage. You can go to a body piercing salon to help you remove your piercings.

What if there is an infection near my body jewelry?

Please let the nurse know that you may have an infection near your body jewelry.

When can I put my jewelry back on?

Except for hand or foot surgery, you can put your jewelry back on after you return home or when you are on the hospital unit.

What if I cannot put it back on myself?

A family member may be able to help you put your jewelry back on. For a small fee, a body piercing salon can put body piercings back in.

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Preadmission Information for Surgical Patients

Thank you for choosing Mackenzie Health as your Surgery Care provider. The information below will help you prepare for your Surgery. You may have a preadmission appointment before the day of your surgery. Or you may come directly for surgery without needing any appointments to prepare you. Before your visit, a representative from Mackenzie Health may call you to confirm any missing registration information such as your address, OHIP number etc.

Hospital Visits	Date	Scheduled Appointment Time
Preadmission:		
Surgery:		

Registering for your Visit with us

When you come to the hospital, we ask that you please check in using our self-serve kiosks, located in Patient Registration, on the 2nd Floor, C Wing. Once you have checked in using a kiosk, you will be directed to a Registration Staff member to apply your wristband,.

If you are staying overnight, they will ask you about any insurance coverage and the type of room accommodation that you would like. They will ask you to sign a billing consent form.

We do have e-check in. If you would like to update registration information or E-Check In 48 hours prior to your appointment, please visit our website at http://mackenziehealth.ca.

For each visit, please come before your appointment time to register.
For Preadmission visits, please come **30 minutes** in advance of your appointment time.
For the Day of Surgery, please come **2 hours** prior to your surgery time.

Pre-admission: Before your Visit

Your Preadmission Visit will help us prepare you for surgery. You will see a nurse, an anaesthesiologist and if necessary a medicine doctor. Your surgeon may have sent you for blood and ECG before your visit. If not and you need it, we will take it during your visit.

In your information package, you have a **Pre-anaesthetic Questionnaire**. Please fill this form out completely. The information that you share with us will help us to provide you with the best care possible. Please bring this to your Preadmission appointment or fill it out and drop it in our surgery patient drop box. The drop box is located at the C wing entrance by the information desk.

For every visit, please bring:

- Your health card,
- Your medications and herbal remedies in their original containers
- An escort to help you understand all the information and to take you home after your surgery.
- Your parent or guardian if you are under 18 years old. If you are staying overnight, we will ask you for your insurance coverage information.

Day of Surgery: Preparing for your procedure

For your safety, we ask that you closely follow these instructions.

Do:

- Take only the medications that your doctor has told you to take on the day of surgery.
- Bring all your medications with you to the hospital
- Take a shower or bath before your surgery
- Remove make up, lipstick, nail polish
- Remove jewelry from all piercings
- Wear loose fitting clothing and shoes with low heels
- Brush your teeth the morning of your surgery
- Bring your health card with you
- Bring a responsible adult to take you home. For your safety, if you do not have an adult to take you home, we will cancel your surgery. You must also have a responsible adult stay with you overnight on the day of your surgery.

Do not:

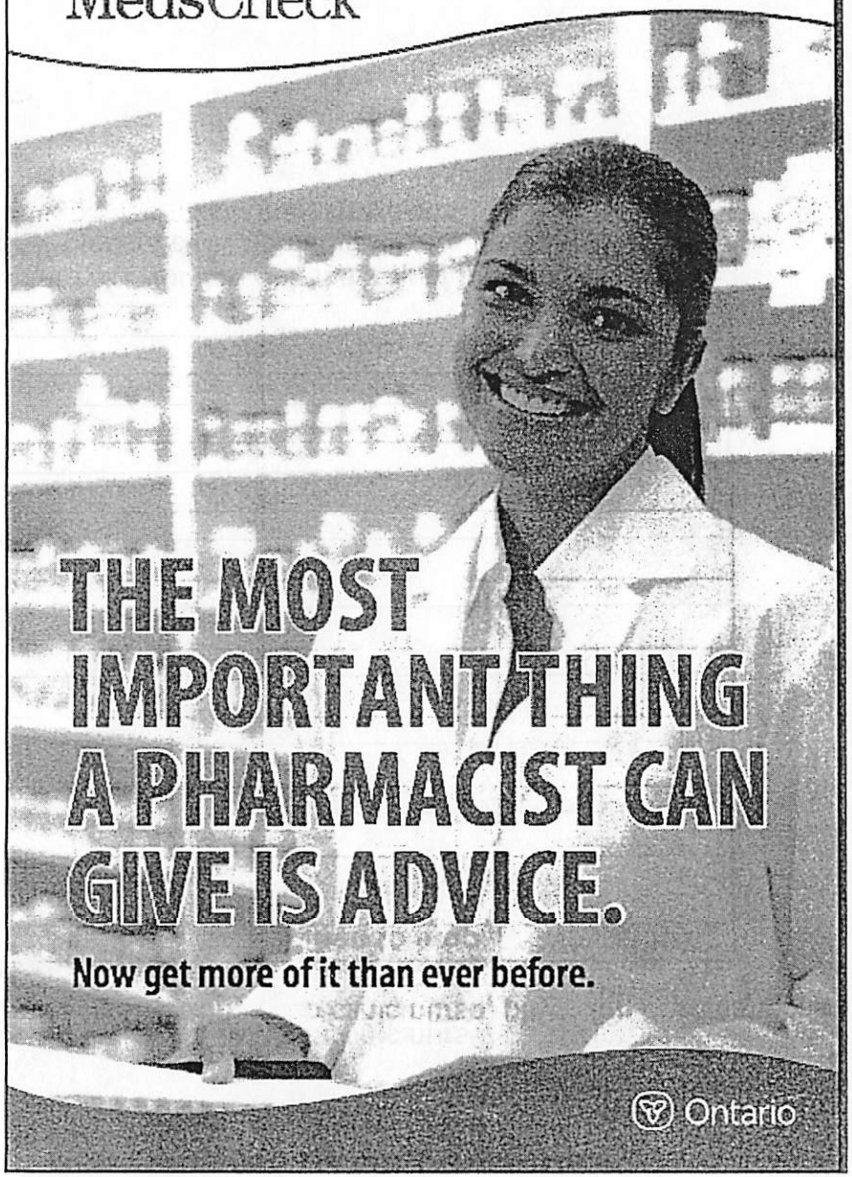
- Eat or drink after midnight the night before your surgery. Unless instructed to do so, please do not suck on candy or chew gum
- Bring your wallet or any other valuables (The Hospital is not responsible for lost valuables)
- Wear contact lenses on the day of surgery
- Drive for 24 hours.

For Day Surgery, please bring:	**For An overnight stay**, please bring:
• Your puffers (if you use them)	• Your pajamas • Comb, brush, toothbrush and toothpaste • A box of tissues and shaving supplies

Some important details:

- If you are staying overnight with us, please note that discharge time is 9:00 am. Please make arrangements for someone to take you home by this time. If you are unable to leave at this time, you may be asked to sit in our lounge while you wait for your ride home.
- While you are with us, we will do our best to meet your accommodation requests. If you wish to change your requested accommodation, please let the nurses know.
- We encourage your family and friends to visit. Have them check in at the nursing station before coming to your room.
- We recommend that you stop smoking at least 1 month before surgery. If you require assistance, please ask a team member for information.
- Mackenzie Health is a non-smoking facility. All buildings, grass areas and parking lots are smoke free. There is a fine for smoking on the grounds.
- If you develop a cold, the flu or an infection, it is important for your Surgeon to know. Please tell them.
- Our goal is to do your surgery at the scheduled date and time. There may be circumstances that prevent us from proceeding with your procedure. This could be things like your health status, bed availability, timing of surgery. If this is the case, we will post pone your surgery to another date.
- If you require care after the hospital, our team will work with our Community Care access centre coordinator to set up resources to support you.

MedsCheck



Welcome to

MedsCheck

MedsCheck is a new, private consultation with your pharmacist that ensures you're getting the most from your medications and that you're taking them correctly.

1. **Who is eligible:** Ontarians who have a chronic condition and are taking 3 or more prescription medications.
2. **What it is:** An opportunity to meet with your pharmacist privately, once a year, for up to 30 minutes. It's a free service. Just bring your OHIP card.
3. **How you benefit:** Your pharmacist will help you manage your prescription medications and better understand how they interact with each other and other over-the-counter medication you may be taking.

Three things you'll need to bring to your appointment.

1. Your Ontario Health Card.
2. Any current medication containers, including those from other pharmacies, or a list of all your medications.
3. Any over-the-counter drugs, vitamins and/or herbal remedies you are currently taking.

Book your free, private MedsCheck appointment today.

Your pharmacist is looking forward to your visit and will book a convenient time for you to meet. Simply refer to your pharmacist's contact information provided in the box below.

For questions only, call INFOline at
1-866-255-6701 or TTY number 1-800-387-5559.
Or visit www.medscheck.ca

Medications to Discontinue Prior to Surgery*

(to be completed by Pre-admission clinic nurse, physician or pharmacist)

Medication	When to stop	Why stop?

* If your doctor asks you to continue any of these medications, please follow their directions.

Mackenzie Health

ismp CANADA

Ontario

MedsCheck

Pre-Admission Clinic Medication Information

You will be seeing a nurse (or a health-care professional) during your pre-admission clinic appointment. The nurse will ask you about your medications – prescription, over-the-counter, vitamin and herbal.

This information will become your best possible medication history and the surgeon and other health-care professionals will use it during your hospital stay. Please bring all your medications with you on your appointment visit.

Many patients are using the *MedsCheck* program offered by their community pharmacist at the time of the hospital clinic appointment.

MedsCheck is a unique program paid for by the Ministry of Health and Long-Term Care. If you are taking 3 or more medications for a chronic condition(s), we recommend that you arrange a *MedsCheck* with your community pharmacist 1-2 weeks before your pre-admission clinic appointment.

Your community pharmacist will review your medications and give you a complete list that includes your prescription and over-the-counter medications. It is important to bring the *MedsCheck* list with you to your pre-admission appointment.

Name of your community pharmacy:_____

Telephone Number: _____

My *MedsCheck* is on (date)_____at (time)_____.

If there are any changes to your medications after you meet with the pre-admission nurse, please tell the surgical day care nurse on the morning you come in for surgery.

We will let you know if there are medications you need to stop taking before your surgery.

Carry an up to date medication list with you.