CAMBIE SURGERY CENTRE
PRE-OPERATIVE EVALUATION

Patient's Name: _____ Date: _____

Allergies or Sensitivities (describe reaction): _____
_____

Do you have a **Latex allergy** or do you have a problem with the rubber dam used for dental work? **Yes** ☐ **No** ☐

Have you ever had a reaction to X-ray contrast dye? **Yes** ☐ **No** ☐ Height: _____ Weight: _____

Do you have or have you ever had any of the following:	Yes	No	If YES please describe below
History of chest pain, angina or a heart attack			
Chest pain, angina or shortness of breath in past 6 months			
Heart surgery, angioplasty, stents, or angiogram			
Do you have a pacemaker/ implanted defibrillator			
Heart murmur or known heart valve disease			
Abnormal ECG, irregular pulse or palpitations			
High blood pressure? If yes, list medications/ diuretic			
Able to lay flat for 30 minutes			
Able to climb 2 flights of stairs? If not what stops you?			
Stroke, TIA, History of DVT (blood clots)			
Do you take pills to thin your blood (Including Aspirin/ASA)			
Do you take antibiotics before dental work			
Asthma/ Bronchitis/ Emphysema/ Wheezing			
Productive cough/ Chronic cough			
Severe snoring or sleep apnea (stop breathing while asleep)			
Do you smoke			
Have you quit smoking? If yes, specify when			
Abnormal Chest X-Ray			
Kidney/ bladder/ urination problems			
Heartburn/ Hiatus Hernia/ Acid Reflux			
Stomach or duodenal ulcers			
History of Hepatitis (Hep B or C) or a positive HIV test			
Liver problems			
Diabetes? If yes do you take insulin?			
Thyroid problems			
Bleeding disorders/ Anemia/ Thalassemia/ Hemophilia			
Rheumatoid Arthritis/ Ankylosing Spondylitis			
Blackouts/ Seizures/ dizzy spells/ fainting			
Tumors/ Malignancy			
Hospitalized for any psychiatric condition			

Do you have or have you ever had any of the following:	Yes	No	If YES please describe below
Back Trouble/ Fracture/ Herniated Discs			
Chronic Pain			
Possibility of Pregnancy			
Do you take Oral Contraceptives (If yes please list)			
Do you take Hormone Replacement (If yes please list)			
Do you drink more than one alcoholic drink per day			
Have you used narcotics/illegal drugs in the last month			
Any infectious illnesses/ exposure to infectious illnesses in the last month (eg. shingles/measles /mumps/influenza)			
Any other serious illnesses/ conditions that we have not mentioned			
Have you had previous anesthesia			
Any problems with anesthesia			
Family problems with anesthesia			
Do you have any difficulty opening your mouth or moving your neck			
Any previous Post-Op complications			
Have you ever had one of the following: Exercise Stress Test (treadmill) Nuclear Medicine Heart Scan (MIBI) Heart Echo (heart ultrasound) Holter Monitor Lung Function Test			(if yes please give year/date/location)
In the past 5 years have you seen any of the following: Cardiologist (heart specialist) Respirologist (lung specialist) Neurologist/ Neurosurgeon (nerve/ brain specialist) Psychiatrist Other type:_____			(if yes please give name/year/date/location)
Have you had any previous surgical operations? Please list type of operation, the hospital/date and surgeon.			
Do you take medications			
If YES Please list the name and the dosage of all medications: (includes blood thinners/diuretics/contraceptives/ vitamins/ herbs)			

My signature authorizes the Cambie Surgery Centre authority to access all my personal health information recorded elsewhere, for the purpose of providing care and treatment.

(Patient Printed name) (Patient Signature) (date)

CAMBIE SURGERY CENTRE

CONSENT FORM

I hereby authorize and request Dr. _____, along with any assistants he/she feels necessary, to perform upon me the following treatment, procedure or surgical operation(s):

_____

_____

I also authorize the attending physician to provide any additional treatment or investigation that in his/her judgement may be advisable for my immediate well-being.

The nature of the planned operation has been thoroughly explained to me and I have decided to proceed with this procedure over other alternate methods. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made about the results of the operation or procedure planned. Furthermore, the risks and complications inherent in the operation have been explained to me and I accept these.

I further give permission to have such anaesthetics administered to me as the attending physician(s) or the anaesthetist deem necessary or advisable.

Pictures may be taken of the treatment site for record purposes. I understand that these photographs/videos will be the property of the attending physician. **I do** / **do not** agree to allow these pictures to be used for publication or teaching purposes. If I agree, I understand that my name and identity will be kept confidential and protected.

I further consent to the drawing and testing of my blood for risk assessment purposes in event of inadvertent exposure of doctors or clinic personnel to my blood or body fluids during the course of the procedure or pre or postoperative care and the release of the results of such testing to my physician and public health authorities in accordance with BC Centre for Disease Control policy.

I agree to keep the surgeon's office informed of my post operative progress and I agree to follow the instructions given for my post operative care.

I hereby acknowledge receiving a copy of the post-operative instructions which have been reviewed with me. I understand the advice and restrictions given and agree to abide by them. I will notify my doctor immediately if any unusual bleeding, respiratory problems, or acute pain occurs after my discharge from Cambie Surgery Centre.

I have been informed by the surgeon and understand that the use of their IOL chosen is for Refractive reasons and/or for Dysfunctional Lens Syndrome ("off label" use as per College of Physicians & surgeons of BC)

I have read the above information, and understand its contents; I consent to the surgical procedure.

Signature of Patient or Legal Guardian: _____

Name (Please print): _____

Relationship (If Legal Guardian): _____

Witness: _____

Date: _____

CAMBIE
SURGERY CENTRE

Name: _____

Obstructive Sleep Apnea (OSA) screening

STOP-Bang Questionnaire

S	Do you **snore** loudly (loud enough to be heard through closed doors)?	❑YES	❑NO
T	Do you often feel **tired**, fatigued or sleepy during the daytime?	❑YES	❑NO
O	Has anyone **observed** you stop breathing during your sleep?	❑YES	❑NO
P	Do you have or are being treated for high blood **pressure?**	❑YES	❑NO
B	**BMI** greater than 35?	❑YES	❑NO
A	**Age** greater than 50 years old?	❑YES	❑NO
N	**Neck** circumference greater than 40 cm / 16 inches?	❑YES	❑NO
G	Male **gender**?	❑YES	❑NO
High Probability of OSA **Total "YES" = 5 or more**			
Measured Height/Weight **Height: _____ (cm/ft)** **Weight: _____ (lbs/kg)** **BMI: _____**			