# Pre-op Screen Patient Form

Date of surgery _____ Surgeon's Name _____

Operation: _____

- Answer **ALL** questions, front and back. Place N.A. (not applicable) by questions if it does not pertain to your child.
- Call (901) 287-6273, Monday through Friday, between 9 a.m.–5 p.m. if you have a question.
- Surgeon's office will fax this completed form to fax number 901-937-3335.
- Please call the Pre-Op Screening office at 901-287-6273 if your phone numbers change before the surgery date.

## Patient Information

| | | | | |
|---|---|---|---|---|
| Patient's Name | Last | First | M.I. | Name Called |
| Date of Birth | | Age | Sex | Race |
| Home Phone Number ( ) | | Cell Phone Number ( ) | | Cell Phone Number ( ) |
| Work Phone Number ( ) | (Employee Name) | | Extension Number | |
| Emergency Name | | | | Emergency Phone Number ( ) |
| Legal guardian(s) _____ | | | | |
| Adopted ☐ No ☐ Yes | | If yes, date of final adoption | | |

Has your child been exposed to chicken pox, measles, mumps in the last 3 weeks? ☐ No ☐ Yes
Has your child been exposed to or diagnosed with TB? ☐ No ☐ Yes
Has your child been exposed to or diagnosed with HIV? ☐ No ☐ Yes
Have you given your child aspirin, Advil, Motrin (not Tylenol or Tempra) in the last 2 weeks? ☐ No ☐ Yes
Are your child's immunizations (baby shots) up to date? ☐ No ☐ Yes

## Anesthesia Information

**1.**

Did your child have any problems when he/she was born or require a longer than normal hospitalization? ☐ No ☐ Yes If yes, how long?

Was your child born early? ☐ No ☐ Yes Birth weight:

How many weeks did pregnancy last?

Was your child on a machine/respirator to help him/her breathe? ☐ No ☐ Yes If yes, how long?

**2.**

Please list your child's surgeries and dates performed. _____

_____

None _____

**3.**

Please list your child's hospitalizations and dates admitted. _____

_____

None _____

**4.** Has your child or family member ever had a problem with anesthesia (such as MH)? ☐ No ☐ Yes
If yes, please explain briefly.

**5.** Has your child or family member been diagnosed with muscle disease (such as MD)? ☐ No ☐ Yes
If yes, please explain briefly.

**6.** Has your child or family member ever had a bleeding problem? ☐ No ☐ Yes
If yes, please explain briefly.

**7.** Does your **CHILD** have any of the following problems? Circle if appropriate and answer each item.
If yes, please list special doctor(s) that follow him/her?

| | | | Doctor |
|---|---|---|---|
| Heart problems (murmurs, irregular beats) | ☐ No | ☐ Yes | _____ |
| Lung problems (asthma, pneumonia, cystic fibrosis, wheezing) | ☐ No | ☐ Yes | _____ |
| Liver problems (jaundice hepatitis) | ☐ No | ☐ Yes | _____ |
| Kidney problems (failure, dialysis) | ☐ No | ☐ Yes | _____ |
| Syndromes | ☐ No | ☐ Yes | _____ |
| Neurological problems (seizures, developmental delay, retardation) | ☐ No | ☐ Yes | _____ |
| Blood disorder (bleeding problems, anemia, sickle cell disease) | ☐ No | ☐ Yes | _____ |
| Frequent vomiting, GI reflux (GERD) | ☐ No | ☐ Yes | _____ |
| Endocrine problems (diabetes, thyroid) | ☐ No | ☐ Yes | _____ |
| Is your child presently on a monitor, oxygen, ventilator, CPAP:? | ☐ No | ☐ Yes | _____ |
| Current upper respiratory infection (cold, runny nose, wheezing)? | ☐ No | ☐ Yes | _____ |

**8.** Please list your child's medications including dosage and frequency taken. (Include over the counter medications)

_____

_____

_____

**9.**

| | | | If yes, explain |
|---|---|---|---|
| Does your child have any drug allergies? | ☐ No | ☐ Yes | _____ |
| Does your child have any food allergies | ☐ No | ☐ Yes | _____ |
| Does your child have any environmental allergies? | ☐ No | ☐ Yes | _____ |
| Does your child have a Latex allergy? | ☐ No | ☐ Yes | _____ |

**10.** Does your child have any dental cavities, or loose/damaged teeth? ☐ No ☐ Yes
If yes, please explain. _____

**11.** First day of your child's last menstrual period (if applicable). _____

**12.** Does your child feed him/herself? ☐ No ☐ Yes
Please circle if your child eats baby food, table food, or receives G-tube feedings. Please list all special dietary needs.

_____

_____

| Completed by: | Relationship to patient: | Date: |
|---|---|---|
| | | |

## Pre-Admission Information

| | |
|---|---|
| Date and time to be admitted: | Patient's regular doctor or clinic: |
| Has your child ever been a patient through the Emergency Department or Outpatient Services? (example: X-ray, Re-hab, etc.) | |
| Reason for surgery? | |

## Patient Information

| | | | |
|---|---|---|---|
| **Patient's Full Name** | | Child's Social Security Number: | |
| Last Name: | First Name: | | Middle Initial (M.I.): |
| Street Address: | | | |
| City: | State: | County: | Zip Code: |
| Month: Day: Year: | Birth County: | Birth State: | |
| Age: | Sex: | Race: | Phone Number: ( ) |
| Religious Preference: | Is Your Child A Known Diabetic: | | |

### Natural Parent or Legal Guardian

| | | | | |
|---|---|---|---|---|
| Relationship To Patient: | | | Date of Birth: | |
| Last Name: | M.I. | Maiden Name: | First Name: | |
| Street Address: | | City: | State: | Zip Code: |
| Social Security Number: | | Residence Phone ( ) | Work or Cellular Phone ( ) | |
| Employer Name: | | Employee Occupation: | | |
| Street Address: | | City: | State: | Zip Code: |

## Notify In Case Of Emergency (Other than Parent)

| | | |
|---|---|---|
| Last Name: | First Name: | Middle Initial (M.I.): |
| Relationship: | | Phone Number: ( ) |

## Notify In Case Of Emergency (Other than Parent)

| | | |
|---|---|---|
| Last Name: | First Name: | Middle Initial (M.I.): |
| Relationship: | | Phone Number: ( ) |

If your child is **not** covered by insurance or Medicaid, please contact us **before** your admitting date at (901) 287-6374.

**Parents: If your insurance carrier requires their own claim form, please present at time of admission.**

## Responsible party For Payment of Bill

| | | | |
|---|---|---|---|
| Last Name: | First Name: | M.I. | Phone: ( ) |
| Street Address: | City: | State: | Zip Code: |
| Relationship to Patient: | Social Security #: | | |

## Insurance Information

*Please be certain that you have the correct mailing address for the employer that holds the group policy under which your child is covered*

**Primary**

| | | | |
|---|---|---|---|
| Insurance Company Name: | | | |
| Policy #: | Group #: | | |
| Group Policy Holder (Employer Name): | | Employer Phone Number: ( ) | |
| Street Address: | City: | State: | Zip Code: |
| Subscriber's Full Name: | | | |
| Social Security #: | | | |

**Secondary**

| | | | |
|---|---|---|---|
| Insurance Company Name: | | | |
| Policy #: | Group #: | | |
| Group Policy Holder (Employer Name): | | | |
| Street Address: | City: | State: | Zip Code: |
| Subscriber's Full Name: | | | |
| Social Security #: | | | |

**Individual TennCare/Medicare**

| | | | |
|---|---|---|---|
| Insurance Company Name: | | | |
| Street Address: | City: | State: | Zip Code: |
| Subscriber's Full Name: | | | |
| Social Security #: | | | |
| Medicaid Number: | | State: | |

*A deposit may be required on each admission not covered by insurance.*
*It is necessary that you have your current Medicaid and/or group insurance card with you at time of admission.*

If any questions, call: (901) 287-6370 – Admission