

SAME DAY SURGERY ADMISSION RECORD

SDS Form 714 3 /09

Reason for Admission: _____
Procedure: _____

PREADMISSION VISIT: Date: _____ B/P _____ Pulse _____ Test to be done on admission: _____
Notes: _____

**Admission Date: _____ Time: _____ Mode: Ambulatory W/C Other _____
HEALTH HISTORY and ASSESSMENT: Historian: Patient/Family member Transfer sheet Prior medical record Other _____
**Previous Hospitalizations/Surgeries: _____

**Anesthesia Reactions: None N/V B/P Respiratory Fever Family History Slow to awaken Other _____
Comments: _____
**Vital Signs: Height: _____ Weight: _____ scale stated B/P _____ P _____ R _____ T _____ SaO2 _____
**ALLERGIES: None _____

**Impairments: Hearing: Left Right _____ Vision: _____
**Habits: Alcohol: _____ Tobacco: _____ Street Drugs: _____
**Emotional Status: Calm Cooperative Anxious Other _____
**Mental Health: Depression Anxiety Other _____
Customs/Religious Practices affecting care: _____ **Advance Directives: none-info provided Living Will DPA DNR ID On file

NEUROLOGICAL: No deficits
 Numbness / Tingling: _____
 Weakness Dizziness Syncope Headache
 Tremors Seizures CVA/TIA Paralysis _____
 Orientated Confused
Comments: _____

MUSCULOSKELETAL: No difficulty
 Pain Arthritis: *Areas Affected:* _____
 Fibromyalgia Osteopenia/Osteoporosis Back/Neck problems
Equipment for ADL: _____
Comments: _____

CARDIOVASCULAR: No difficulty
 Chest Pain: At Rest With exertion MI Pacer/IED
 HTN CAD CHF MVP / Murmur
 Dysrhythmia: _____ Hyperlipidemia
 Bleeding/clotting disorder _____ Anemia Fatigue
Apical Pulse: Regular Irregular **Edema:** No Yes _____
Peripheral pulses (if applicable)
Radial right _____ left _____ Pedal right _____ left _____
Comments: _____

GENITOURINARY GYN: No difficulty
 Hematuria Dysuria Frequency Urgency Hesitancy
 Retention Nocturia Incontinence Kidney Stones
LMP _____ Post Menopausal / Hysterectomy
Comments: _____

Respiratory: No difficulty
Dyspnea: At rest Exertion Asthma COPD
 Chronic bronchitis Sleep Apnea _____
Cough: Nonproductive Productive _____

Breath Sounds: _____
Comments: _____

ENDOCRINE: No difficulty
 Hypoglycemia Diabetes Thyroid

GASTROINTESTINAL: No difficulty
 Nausea / Vomiting Dysphagia Heartburn / reflux
 Diarrhea / Constipation Hiatal Hernia Diverticular Disease
 Hepatitis Cirrhosis
Current Diet followed: _____
Comments: _____

INTEGUMENTARY: No difficulty See Form # 1457
**Condition/Color: Hot Warm Cool Pale
 Dry Moist Other Pink
Comments: _____

*****PAIN ASSESSMENT:** Denies Pain
Word to describe Pain: _____
Intensity (0-10) _____
Location: Quality, patterns of radiation: _____

Duration: Time of onset, duration, variation and pattern _____

Alleviation/Aggravation factor: What makes the pain better? _____

What makes the pain worse? _____
Pain other than site of present complaint: _____

N/A
Other: Cancer Autoimmune disorder
Comments: _____

**Only sections that need completed if patient receiving local anesthesia.
Admitting Nurse: _____

Transported to OR per cart @ _____					
Unit Nurse _____					
OR Nurse _____ Report received from _____					

* Date and initial as sections are completed. When patient admitted in SDS Department ✓ is sufficient.