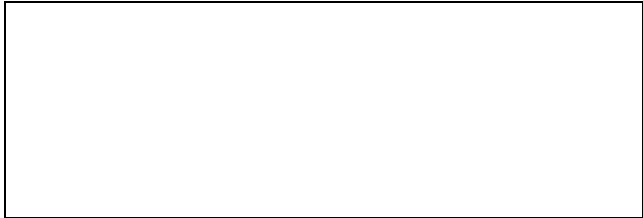




111 Michigan Avenue, NW, Washington, DC 20010



Surgeon's office to complete the following:

Fax completed form to: _____ Date of surgery: _____

Pre-op diagnosis for surgery: _____ ICD-9 code: _____

Proposed procedure: _____

Surgical History & Physical - Interdisciplinary Patient Assessment

Chief Complaint: _____

History of Present Illness/Injury: _____

Is the Patient in Pain: YES NO If Yes, complete:

Wong-Baker Faces Pain Rating Scale
(Recommended for children ≤ 3 year)



Numeric Scale
(For older children and adolescents)



Location: _____

Frequency: _____

Duration: _____

Character: Dull Sharp Throbbing

Review of Systems (circle if the patient has had a recent):

Cough Rhinorrhea Fever Pneumonia (in preceding 4 weeks) Diarrhea Nausea/Emesis

Other: _____

Call Pre-Operative Care Clinic (202 476-5966) or Surgeon's office if the following:

Wheezing in the past week Recent fever > 100.7°F or 38°C Pneumonia in the prior 4 weeks

Past Medical / Surgical History (circle if the patient has or has had):

Asthma/Reactive Airway Disease GERD Congenital heart disease Heart murmur Prematurity: ____ weeks

Other: _____

Family History/Psychosocial Assessment: _____

Allergies/Reactions: Yes No Family h/o anesthesia problems: Yes No

Bleeding Disorders / Tendencies: Yes No

If Yes to above, describe: _____

Immunizations Up To Date: Yes No Date of Last Menstrual Period _____ N/A _____

Current Medications: _____

PLEASE TURN OVER →



HNP

Legend: Place an 'X' if abnormal, "√" if normal, and leave blank if not examined.

Physical Exam

Temp: _____ HR: _____ RR: _____ BP: _____ / _____ HT: _____ WT: _____ HC: _____

Mandatory:

Cardiovascular _____ Lungs _____

If Applicable:

<input type="checkbox"/> General Appearance (State) _____	<input type="checkbox"/> Mouth / Teeth / Pharynx _____	<input type="checkbox"/> Skin / Scalp _____
<input type="checkbox"/> Head / Fontanel _____	<input type="checkbox"/> Lymph Nodes _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Ears _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Skeletal (Back, Hip, Extremities) _____
<input type="checkbox"/> Eyes _____	<input type="checkbox"/> Genitals _____	<input type="checkbox"/> Development / Growth _____
<input type="checkbox"/> Nose _____	<input type="checkbox"/> Anus / Rectum _____	
<input type="checkbox"/> Other, describe: _____		

Labs / Radiology (if pertinent): _____

Assessment (Medical or Surgical Indications for Admission):

Plans: _____

Education (*must be checked*):

Diagnosis, Medications, & Treatment Plan discussed and reviewed with patient / family

I certify that this patient is medically cleared for surgery:

Resident/Fellow Signature: _____ Print Name: _____

(Mandatory) Physician/LIP Signature: _____ Print Name: _____

Date: _____

24 Hour Update: My signature attests that indications and plans for surgery are unchanged.

Surgery Attending Signature: _____ Date: _____

Print Name: _____

