Women and Infants'
Patient Pre-Operative Summary

Patient's Name: _____ Date of Birth: ____/____/____

Surgical PAT Needs Assessment Date received: ____/____/____
Surgeon: _____ Surgery Date: ____/____/____
Surgical Procedure: _____
PAT Signature: _____

Pre-Operative Testing ___ yes ___ no Date performed: ____/____/____
Location: ___ WIH
___ Outside facility (Name: _____)
PAT Signature: _____

PAT Evaluation ___ yes ___ no Date performed: ____/____/____

Anesthesiologist: _____
Recommendation(s): _____

Medical Evaluation ___ yes ___ no Date performed: ____/____/____

Internist: _____
Recommendation(s): _____

Pre-Operative Check List	**Yes**	**No**
Surgeon History and Physical (must be in chart **24 hours** prior to surgery date)	___	___
Surgical Consent (must be in chart **24 hours** prior to surgery date)	___	___
Pre-Operative Tests	___	___
Anesthesia Evaluation (if applicable)	___	___
Medical Evaluation (if applicable)	___	___
Other(s): _____	___	___
CHART IS COMPLETE FOR SURGERY	___	

Surgery Day Check List The following have been ordered for the day of surgery.

__ Urinalysis dipstick
__ Pregnancy test (age under 50 years, unless known pregnancy)
__ Finger stick glucose
__ PT/INR/PTT
__ Type and Screen
__ Type and Cross
__ Antibiotic(s)
__ Atenolol protocol
X Venous thromboembolism prophylaxis protocol (**all patients**)
__ Endocarditis prevention protocol
__ Stress dose steroid protocol
__ Notify Obstetric and Consultative Medicine (401-274-1122 ext. 1134, 1923, or 1925)
__ Others: _____