Preoperative Testing Tip Sheet

Patient Name:_____

Patient Date of Birth:_____

Date Form Completed:_____

IF **yes**, take the following action in reference to the Preoperative Optimization Grid

Yes	No	Pacemaker or AICD (Internal Defibrillator)	1.b.
Yes	No	Stroke or TIA	1.f.
Yes	No	Chronic Obstructive Pulmonary Disease, Severe Asthma, or Shortness of Breath	2.a.
Yes	No	Sleep Apnea	2.b.
Yes	No	Kidney Disease, Chronic Renal Insufficiency	2.d.
Yes	No	On Dialysis	2.c.
Yes	No	High Blood Pressure	2.e.
Yes	No	Liver Disease, Hepatitis	2.f.
Yes	No	Alcohol or Drug Abuse	2. f.
Yes	No	Diabetes: If yes, do you take insulin, or have an insulin pump?	2.h. Pump agreement form is required for insulin pumps
Yes	No	On Aspirin or blood thinners	3. a
Yes	No	Diuretic Use (Lasix, HCTZ, Fluid Pills)	3. b.
Yes	No	Smoker or Former Smoker? How Much? How Long?	
Yes	No	Have you had a recent respiratory infection?	See Guidelines for acute disease processes if applicable
Yes	No	Are you currently taking medications to assist with weight loss	See Guidelines for GLP-1 Agonists if applicable
Yes	No	Are you currently on steroids, either oral or inhaled?	*Notify Posting*
Yes	No	Positive PPD- screening test for tuberculosis (positive tuberculosis/TB)	*Notify Posting*

Cardiac	Are you under the care of a Cardiologist? Y N	
	Name of Physician	
	Have you had any of the following Cardiac Events in the last year? (Circle ones that apply)	
	Heart Attack (MI), Angina/Chest Pain, Arrhythmia, Atrial Fibrillation, Angioplasty, Cardiac Stent	1.a.
	Heart Failure	1.c
	Aortic Stenosis, Mitral Stenosis	1.d.
	Pulmonary Hypertension	1.e.

Pulmonary	Are you under the care of a Pulmonologist? Y N	1.e. or 2.a.
	Name of Physician	

Power of Attorney	Please provide and scan all Power of Attorney Documentation into EPIC

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