Patient leaflet

for operation or procedure under anaesthesia

PATIENT STICKER

az delta

Uw ziekenhuis.

This patient leaflet is realised in cooperation with the following associations.

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Dear patient

In this patient leaflet you will find all the information and forms that have to be filled in for your operation or procedure under anaesthetic. This must occur before admission to let that admission run smoothly.

About two weeks before the planned procedure, please visit your general practitioner.

If you take **BLOOD THINNERS** or are **ALLERGIC** please inform your doctor.

For further information, or if you have any questions, or if you would like to consult with the anaesthetist beforehand, please contact the admission department or the anaesthetics secretariat.

Admission department

Campus Rumbeke
Deltalaan 1
8800 Roeselare
051 23 72 55

Campus Brugsesteenweg
Brugsesteenweg 90
8800 Roeselare
051 23 64 64

Campus Menen
Oude Leielaan 6
8930 Menen
056 52 20 32

Campus Rembert Torhout
Sint-Rembertlaan 21
8820 Torhout
050 23 27 46

e-mail: **preopbeleid@azdelta.be**

Anaesthetics department

Campus Roeselare / Menen
Secretariat : 051 23 70 39
E-mail: **secretariaat.anesthesie@azdelta.be**

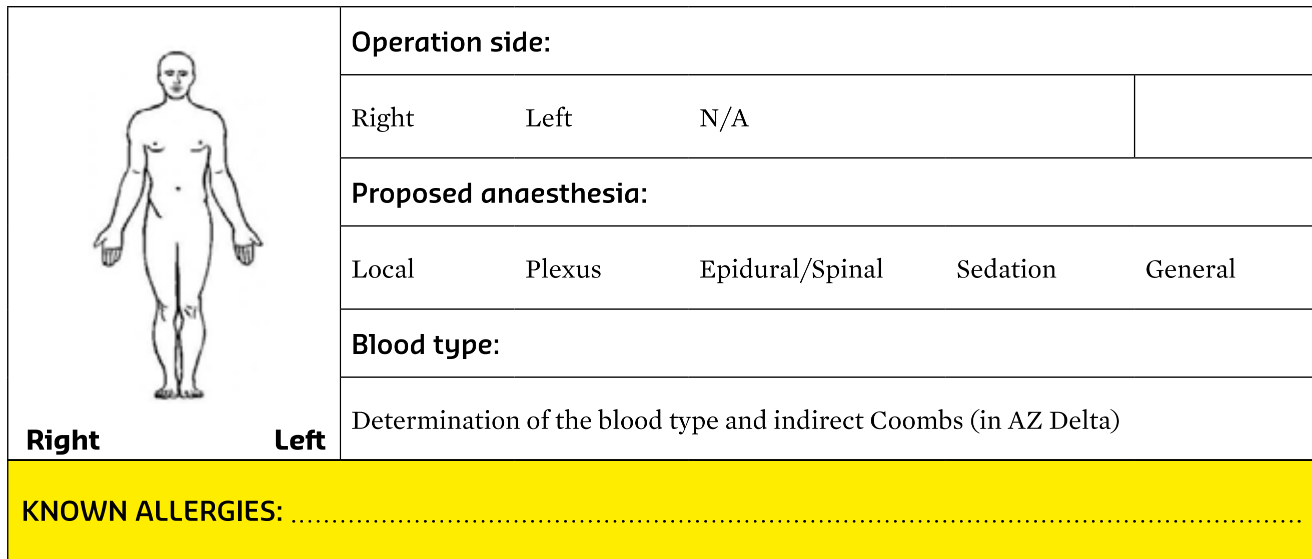
PATIENT STICKER

CAMPUS: Rumbeke Brugsesteenweg Menen Torhout

TYPE OF ADMISSION: Hospitalisation Outpatient surgery Post-op admission IZ

PROBABLE DURATION OF STAY: .... days

ADMISSION DATE:	TIME:	DATE OF OPERATION: ....
REASON FOR ADMISSION:	ELECTIVE	(SEMI) URGENT
....		



Right Left	Operation side:	
	Right Left N/A	
	Proposed anaesthesia:	
	Local Plexus Epidural/Spinal Sedation General	
	Blood type:	
	Determination of the blood type and indirect Coombs (in AZ Delta)	

KNOWN ALLERGIES: ....

COAGULATION POLICY	In case of consultation: name of doctor: Dr.	
Medication:	Last taken:	Replaced by: until:
Medication:	Last taken:	Replaced by: until:

ANY OTHER MEDICATION TO BE STOPPED: ....

TYPE OF PROCEDURE (PLEASE CIRCLE)

minor	intermediary	major
E.g.: Removal of skin lesion, Bartholin gland Drainage chest abscess Carpal tunnel Septumplasty Hydrocoele Cataract Etc.	E.g.: Tympanoplasty Section Lap cholecystectomy Etc.	E.g.: abdominal hysterectomy Joint prothesis (THP, TKP) TUR Prostate Neurosurgery Thyroidectomy Nephrectomy Jugular gland extirpation Major abdominal surgery, etc.

N.B.: IF > 70 YEARS OLD: AT LEAST ASA II

	ASA I	ASA II	ASA III	ASA IV
ASA-classification.	Normal healthy patient	Patient with mild systemic disease	Patient with debilitating systemic disease, that limits normal activity	Patient with debilitating systemic disease, constant threat to life.
	E.g.: Patient with good exercise capacity	E.g.: good treated hypertension, good regulated diabetes, mild obesity, anaemia, slight chronic bronchitis.	E.g.: seriously disrupted hypertension - uncontrolled or disrupted diabetes - moderate angina pectoris, initial cor decompensation	E.g.: angor pectoris when resting - pulmonary insufficiency - kidney insufficiency - cardiac insufficiency - liver insufficiency
Minor procedure	Anamnesis + Clinical evaluation ECG > age 65 Lab if indicated	Idem ASA I + Lab if indicated	Anamnesis + clinical evaluation + Lab + ECG	
Intermediary procedure				
Major procedure	Anamnesis + clinical evaluation Lab + ECG > age 65			

GUIDELINES

☐ **Lab** BG + indirect Coombs: on / /20 (AZ Delta): ☐ **ECG** if indicated: e.g. RX-Thorax, etc.

☐ **Consultation GP** .... Date: ....

☐ **Consultation cardio, pneumo, nephro, endocrino:** .... Date: ....

☐ **Consultation anaesthesist** .... Date: ....

☐ **Pacemaker**	NO	YES	advice on pre-op adjustment of PM
☐ **Defibrillator**	NO	YES	advice by cardiologist
☐ **Neurostimulator present**	NO	YES	bring control device
☐ **Deep Brain Stimulator**	NO	YES	advice neurosurgery
☐ **Subcutaneous insuline pump**	NO	YES	inform the diabetes nurse

REQUIRED CONSENT BY THE PATIENT ON THE BASIS OF INFORMATION ABOUT THE OPERATION/TREATMENT/EXAMINATION

Dr. .... **has informed me on** .... /....... / 20.......

about the following operation/treatment/examination ....

....

on ..../......../ 20........ **on the campus of Rumbeke / Brugsesteenweg / Menen / Torhout**

The doctor has given me more explanation about:
- the health situation and diagnoses and which operation/treatment/examination will be carried out;
- the reason, duration, urgency, nature, goal and frequency of the operation/treatment/examination;
- the chances of success;
- the pros and cons, possible complications and side effects during the procedure and/or recovery period;
- the precautions to be taken inc. necessary examinations before and after the operation/treatment/examination;
- the possible alternatives and the chances of recovery with and without the procedure;
- the cost price and the personal share to be paid as a patient.

I know that I can always ask the doctor any questions. If you have any questions regarding the invoice, please ask the finance department. (factuur@azdelta.be or 051 23 76 66).

I will closely follow the instructions of my doctor to let the operation/treatment/examination and recovery go as favourably as possible. I know that despite the greatest precautions, the doctors and nursing team cannot guarantee absolute success.

I agree that the doctor can carry out additional medical actions – in connection with the original reasons for treatment – that are necessary to recover or to maintain my state of health.

I confirm my consent to the doctor who signs below to carry out the operation/treatment/examination together with another doctor or doctors in training. In exceptional circumstances, the doctor that I have chosen may be replaced by a colleague. I agree that sometimes external operators may be present during the procedure (e.g. representatives of prothesis equipment necessary for the procedure, physical therapists, trainee doctors, trainee nurses, etc.).

I can revise my opinion at any time and decide not to let the procedure go ahead. To this end I will contact the doctor who is treating me.

I give my consent for recording anonymous, photographic data and possibly use it for educational purposes and/or scientific publications.

Drawn up in Menen / Roeselare / Torhout — on ..../......../20........at........am/pm

Patient or legal representative
First name and surname + signature + 'Read and approved'

Attending physician
Signature and stamp

CONSENT TO ANAESTHESIA AND ANALGESIA (PAINKILLERS)

I know that a general anaesthetic and/or loco-regional anaesthetic and painkillers are appropriate for the planned operation or procedure. I give permission in this regard to a recognised anaesthetist.

I have carefully read the "Anesthesie" [Anaesthesia] and "Verblijvende afdeling Chirurgie - Info bij opname" [Surgery department with multi-day stay - Info upon admission] or "Dagziekenhuis chirurgie - Info bij opname" [Surgery with same-day discharge - Info upon admission] information brochures. If you have any questions, please contact the anaesthesia service for more information.

I understand that general anaesthesia and painkillers involve risks. I realise that the risks can be higher if I do not follow the guidelines stated in the brochures. The risks can also be higher depending on my medical condition.
I also declare that I agree with any further hospitalisation if this should turn out to be necessary.

I will have had an empty stomach for the required amount of time before the operation.

On the morning of the operation or procedure I will take my medication with some water unless otherwise prescribed by the attending doctor. (In this regard, please think of blood thinners in particular.)

I will not drink any alcohol until 24 hours have elapsed following the procedure.

I will not leave the hospital unaccompanied. On the first night after the operation, I may not drive a car, ride a motorcycle, moped or bicycle, or operate any machines.

I may not sign any important documents and I may not make any important decisions.

There will be someone staying overnight at my home during the first night after the operation.

I know that the anaesthetist cannot guarantee the outcome of the anaesthesia and/or painkillers. I understand and know that the type of anaesthesia and/or painkillers can be changed without my knowledge if this turns out to be

Drawn up in Menen / Roeselare / Torhout — on ..../......../20........

Patient or legal representative
First name and surname + signature + 'Read and approved'

CONSENT TO BLOOD TRANSFUSION

I hereby declare that I may be given blood products if necessary.

o I have been given the information regarding blood transfusion. ("Anesthesie" [Anaesthesia] information brochure)
o I have understood the information regarding blood transfusion.

o I do NOT wish to be given any blood products. (add certificate)

Drawn up in Menen / Roeselare / Torhout — on ..../......../20........

Patient or legal representative (first name and surname + signature + "read and approved")

To be completed by PATIENT

AGE:	LENGTH:	WEIGHT:

ALLERGY: Yes / No / I don't know ....

If so: to what product? E.g. latex, medication (e.g. antibiotics), banana or kiwi, iodine (disinfectant or contrast medium), or other : ....

Which reaction occurred? E.g.: severe vomiting, skin rash, thick lips, respiratory problems, shock? ....

Please note: When taking antibiotics: only diarrhoea or a yeast infection is a side effect, not an allergy.

PACEMAKER / DEFIBRILLATOR	NEUROSTIMULATOR	DEEP BRAIN STIMULATOR

Question	Yes / No
Have you previously been operated on with a general or local anaesthesia? If so, in what year or at what age, and what operation or treatment?	Yes / No
Have you previously been treated by GP or admitted to hospital for diseases or medical conditions? If so, in what year or at what age and for which conditions?	Yes / No
Did you have an unusual reaction to previous anaesthesia? If so, please describe the reaction very clearly.	Yes / No
Has a family member ever had problems with anaesthesia? If so, please describe accurately:	Yes / No

To be completed by PATIENT

Question	Yes / No
Do you smoke? If so, how many cigarettes ..../ day? How long have you been smoking?	Yes / No
Do you drink alcohol? If so, how many glasses ..../ day or......../ week.	Yes / No
How often do you drink 6 (women) / 8 (men) or more glasses of alcohol per occasion? ○ never ○ less than once a month ○ monthly ○ weekly ○ daily	
Do you use drugs, narcotics or stimulants? Which ones?	Yes / No
For women: could you be pregnant?	Yes / No
Have you had heart problems, heart murmur, arrhythmias, pain in the chest, a stent or blowing through? If so, please describe:	Yes / No
Is your blood pressure too high or too low? What is your normal blood pressure? .... /	Yes / No
In the past year, have you fainted or become unwell? If so, please describe:	Yes / No
Are you easily out of breath and is there pressure on your chest in case of exercise? If so, please describe:	Yes / No
Do you have respiratory disorders, asthma or chronic bronchitis? If so, please describe:	Yes / No
Do you use a CPAP device at night? If so, please bring it with you.	Yes / No
Are you out of breath when resting or lying down?	Yes / No
Do you have varicose veins?	Yes / No
Have you ever had a phlebitis /a blood clot in your leg? Have you ever had a pulmonary embolism (blood clot in the lungs)?	Yes / No Yes / No
Do you have coagulation problems? Do you continue to bleed for a long time after a wound, nose bleed or tooth extraction?	Yes / No
Are you being treated by a haematologist?	Yes / No
Have blood products been administered in the past? If so, did any problems occur?	Yes / No

To be completed by PATIENT

Question	Answer
Do you or have you ever had a kidney problem?	Yes / No
Do you have or have you ever had liver problems e.g. hepatitis, etc.)? If so, please describe:	Yes / No
Have you ever had a stomach ulcer?	Yes / No
Have you ever had a hiatus hernia?	Yes / No
Do you have thyroid problems?	Yes / No
Are you being treated for diabetes? If so, in case of insulin: please bring your glucometer and insulin pen(s) with you.	Yes / No
Have you had a cold recently? Have you had the flue in the past months? Did you have a fever?	Yes / No
Are you HIV positive (seropositive)? Are you MRSA positive (hospital bacteria) or have you had it? Other infections?	Yes / No Yes / No
Do you use cortisone or have you had a cortisone injection in the past 6 months?	Yes / No
Do you or a relative have a muscle disease? If so, please describe:..	Yes / No
Do you have back problems?	Yes / No
Do you have neck problems?	Yes / No
Do you have trouble opening your mouth?	Yes / No
Do you have a neurological disease? (Paralysis or loss of strength, Parkinson, epilepsy, brain haemorrhage, stroke, multiple sclerosis, ...) If so, please describe:	Yes / No
Do you suffer from an illness not named here? Please describe:	Yes / No
Do you have dentures (removable or not), loose teeth, a prothesis or braces, a dental implant?	Yes / No
Do you wear glasses, contact lenses or a hearing aid?	Yes / No

To be completed by PATIENT: HOME MEDICATION LIST

OVERVIEW OF HOME MEDICATION:
PLEASE COMPLETE CLEARLY AND CORRECTLY OR COPY.
BRING ALL THE MEDICATION IN THE ORIGINAL PACKAGING WITH YOU IN THE HOSPITAL'S MEDICINE BAG.

MEDICINE			ADMINISTRATION TIME + NUMBER				REMARK
Name	Dose	form	08:00	12:00	18:00	22:00	
Ex.: Dafalgan forte	1 gram	1 tablet					In case of pain
Ex.: Zocor	40 mg	1 tablet					

Do not forget:
- hormonal preparations (e.g. contraceptive pill)
- sleep medication
- ointments
- painkillers
- injections pens
- puffers
- food supplements
- homeopathy
- cortisone
- medicinal herbs
- eye drops
- something for an upset stomach
- medication patches

Diabetes patients:
- bring glucose meter
- bring insulin

To be completed by the GP

STOP MEDICATION BEFORE PROCEDURE.
ANTI-COAGULATION MEDICATION: (GUIDELINES WEBSITE AZ DELTA)

COAGULATION POLICY	In case of consultation: name of doctor: Dr.		
Medication:	Last taken:	Replaced by:	until:
Medication:	Last taken:	Replaced by:	until:

OTHER MEDICATION: (INFO P. 14)

MEDICATION	DATE STOPPED

To be completed by the GP

Dear colleague

A proper pre-op policy and procedure has various advantages, such as for example a reduction in perioperative morbidity, higher patient satisfaction, better safety, more efficient planning, etc. That is why we are counting on your support. Exams less than 6 months old do not have to be repeated, **unless** the clinical condition has recently changed.

ANAMNESIS

(important information not named in the questionnaire):

....

....

....

CLINICAL RESEARCH

CARDIAC/VASCULAR: **Blood pressure:...... /...... mmHg, Heart rate:...... /min.**

....

....

RESPIRATORY:

....

....

GASTRO-INTESTINAL:

....

....

UROGENITAL:

....

....

NEUROLOGICAL/LOCOMOTIVE:

....

....

INFECTIOUS (MRSA, OTHER?)

....

....

OTHER:

....

To be completed by the GP

TECHNICAL EXAMINATIONS (see guidelines on page 5)

ECG-protocol: ....
(please add the ECG itself or a copy)

MRSA-screening done by: ○ AZ Delta ○ GP ...../...../ 20.........

LAB add protocol or mail the results to **preopbeleid@azdelta.be**

Date blood drawn: ...../...../ 20..... (lab:.................................)

OTHER TECHNICAL EXAMINATIONS: e.g.: RX thorax: only if clinical indication

REMARKS by the **GP** for the **SPECIALIST** and/or**NURSES** on the **WARD**:

....

....

....

GP's stamp Signature Date...../...../20.....

If you have any other medical questions relating to the pre-op policy, please mail to:

preopbeleid@azdelta.be

GP / Medication policy

Please continue administering most chronic home medication, also on the morning of the day of the operation!

N.B..: continue administering anti-arrhythmic agents, in case of ablation seek advice from cardiologist.

MEDICATION THAT MUST BE STOPPED BEFORE ADMISSION!

Take the last time THE DAY BEFORE ADMISSION	
DIURETICS	
ACE inhibitors, SARTANS	exceptions: chronic heart failure and greatly reduced ventricular function (EF<30%): continue on same day
ORAL ANTIDIABETICS/INCRETIN-MIMETICs	except for metformin or combination preparations and SGLT-2 inhibitors (such as Jardiance, Forxiga, Invokana, Steglatro) or the combination products (Xigduo, Vokanamet, Synjardy, Segluromet): STOP 48 hours before procedure
If diabetes type 1: admission at 08:00	admission at 08:00: insert drip containing glucose + administer half dose of insulin - bring insulin pens and glucose meter with you
MEDICATION for the CENTRAL NERVOUS SYSTEM: TCA, SSRIS, lithium (Camcolit®, Maniprex®), antipsychotics, neuroleptics, etc.	
MAO INHIBITORS: Moclobemide®, Selegiline (Eldepryl®)	note: Eldepryl® (treatment of Parkinson's disease): a half dose on the morning itself except: usually do not interrupt, if in doubt contact the Admissions Preparation Service for consultation
THEOFYLLINE: Xanthium®	
ANION EXCHANGERS: Questran®, Colestid®	
FIBRATES: Ciprofibraat®, Hyperlipen®, Fenofibraat®, Lipanthyl®, Lipanthylnano®, etc.	myopathy, rhabdomyolysis, renal insufficiency
NSAIDs (preoperative maintenance therapy)	exception: long-acting NSAIDs (Arcoxia®, Feldene®, Brexine®, Meloxicam®, Naproxen®, Piroxicam®, etc.): stop ≥ 3 days in advance pain control permitting

Medication that must be stopped longer in advance	
ANTI-COAGULATION POLICY	cfr. guidelines website AZ Delta or advice physician
METFORMIN or combined preparation with metformin + SGLT-2 inhibitors or combined preparations	take last time 48 hours before surgery (lactic acidosis and renal failure)
MAO INHIBITOR: fenelzine (Nardelzine®)	Usually do not interrupt, if in doubt contact the prescriber.
FOOD SUPPLEMENTS: St John's Wort, valerian, vitamin E, ginkgo Biloba, garlic, ginseng, red rice, etc.	stop ≥7 days in advance
IMMUNOMODULATORS: Arava®, Humira®, Ledertrexate®, etc.	Usually do not interrupt, if in doubt contact the prescriber of the medicine in question.

AZ Delta and the doctors cannot be held liable for complications arising from the use of the guidelines in this leaflet.