University of Connecticut
Health Center
John Dempsey Hospital
Department of Anesthesiology

Patient Information

Pre-Admission Questionnaire

TO BE COMPLETED BY PATIENT/GUARDIAN

Surgical Procedure: _____ Date: _____

	YES	NO
♦ Do you have any allergies or sensitivities to drugs, dyes, any kind of tape, latex products, foods, etc. If YES, to what? _____	☐	☐
♦ What type of reaction? ☐ RASH ☐ HIVES ☐ NAUSEA ☐ SWELLING ☐ TROUBLE BREATHING		
♦ Do you take any medications daily? (including Aspirin, Birth Control Pills, Alka Seltzer) If YES, what? _____ **Please bring to hospital**	☐	☐
♦ Do you take any herbal products? If YES, what? _____	☐	☐
♦ Do you take any diet pills? If YES, what? _____	☐	☐

NOTE: If you currently are taking herbal/diet remedies, we recommend they be stopped 2 weeks prior to your surgery date.

	YES	NO
♦ Could you be pregnant?	☐	☐
♦ Have you ever smoked cigarettes?	☐	☐
a. How many a day? _____ b. For how long? _____ c. Do you smoke now? _____		
♦ Do you drink alcohol?	☐	☐
a. How many a day? _____ b. For how long? _____ c. Do you drink now? _____		
♦ Have you ever used illicit drugs?	☐	☐
♦ Have you ever had an operation before?	☐	☐
a. If YES, what kind and when? _____		
b. Do you remember what type of anesthesia you had? ☐ General ☐ Spinal ☐ Epidural ☐ Local		
c. Did you ever have a problem with anesthesia? If YES, what? _____	☐	☐
d. Has anyone in your family ever had a problem with anesthesia? If YES, what? _____	☐	☐
♦ Have you ever had a(n): heart attack?	☐	☐
pacemaker?	☐	☐
AICD/implantable defibrillator?	☐	☐
♦ Have you ever experienced: chest pain (angina)?	☐	☐
high blood pressure?	☐	☐
shortness of breath?	☐	☐
pressure in your chest?	☐	☐
palpitations or irregular heartbeat?	☐	☐
abnormal electrocardiogram?	☐	☐

HCH1343

University of Connecticut
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Patient Information

Pre-Admission Questionnaire

	YES	NO	?
♦ Do you snore?			
Do you suspect or have been diagnosed with sleep apnea?			
Have you had sleep studies performed?			
Do you wake at night short of breath?			
Do you have difficulty breathing while climbing stairs?			
Have your lungs ever filled with fluid?			
Can you lie flat in bed without getting short of breath?			
Has anyone ever told you that you have a heart murmur or that you need antibiotics before you have dental work?			
Have you seen a heart doctor in the past? If YES, let your surgeon know. Who is your cardiologist? _____			
	YES	NO	?
♦ Do you have a history of asthma, pneumonia, bronchitis, wheezing?			
Have you ever had an abnormal chest x-ray?			
Do you have a history of tuberculosis?			
Have you had a recent cough or cold?			
Have you seen a lung doctor in the past? If YES, let your surgeon know. Who is your pulmonologist? _____			
	YES	NO	?
Have you had hepatitis, cirrhosis or jaundice?			
Do you have ulcers, gastritis, hiatal hernia, heartburn, or regurgitation?			
Do you have diabetes or trouble with your blood sugar?			
Do you have trouble with your thyroid?			
Have you ever had kidney trouble or kidney stones?			
Do you have arthritis/limited movement?			
Do you have jaw or neck stiffness?			
Have you ever had a seizure, stroke, dizziness, fainting spells, or a weakness in your arms or legs?			
Do you have numbness in your arms or legs?			
Do you have a history of traumatic brain injury?			
Do you have anemia (low blood), bleeding problems, frequent nose bleeds, blood clots, or bruise easily?			
Do you have a history or heaving bleeding after dental work?			
Do you or a member of your family have sickle cell anemia?			
Do you have cancer or have you received radiation or chemotherapy?			
	YES	NO	?
Any religious objection to blood transfusions?			
♦ Any medical conditions we did not ask you about? If YES, what? _____			

_____ _____

Signature of Person Completing Form Date/Time

University of Connecticut
Health Center
John Dempsey Hospital
UCONN Medical Group

Patient Identification

Authorization for Medical/Surgical Procedure

1. I give my permission for the procedure(s) listed below to be done on _____ by or under the direction of _____. (name of patient)
(name of operating practitioner)
2. This medical/surgical procedure is called: _____
_____
In plain language, the procedure is described as: _____
_____
_____
The correct side(s) for this procedure is: ☐ left ☐ right ☐ left and right ☐ not applicable

3. Expected benefits of this procedure have been explained to me by the operating practitioner (*additional comments optional*):
_____
_____
_____

4. Expected risks and complications of this procedure have been explained to me by the operating practitioner (*additional comments optional*):
_____
_____
_____

5. Alternatives to this procedure, if they exist, have been explained to me as well as the consequences of no treatment. I have been informed that there may be unforeseen problems during any procedure. I have been informed that there are no guarantees or warranties about the benefits of any procedure, or about the risks and complications that I may sustain.

6. I agree to the use of anesthesia / sedation as explained to me for this procedure. If I have an anesthesia care provider, I have been informed that such person will obtain separate anesthesia consent.

7. If there is an emergency, or if something unexpected happens during the procedure, I have been informed and accept that my physicians will take whatever emergency measures are needed to help me, including additional procedures, anesthesia, or transfusion of blood components.

8. Physicians other than the operating practitioner, including but not necessarily limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner.

Authorization for Medical/Surgical Procedure

9. Qualified medical practitioners who are not physicians who will perform important parts of the surgery or administer anesthesia will be performing only tasks that are within their scope of practice, as determined under State law and regulation, and for which they have been granted privileges by the hospital.

10. At the discretion of my practitioner(s), there may be students present and /or health care industry representatives who provide technical expertise or who may program implantable devices (e.g., pacemakers).

11. The hospital will oversee the disposition of any specimen(s) or tissue removed during this procedure in an appropriate manner; this may include retaining some of my tissue for research purposes, provided that all links to my identity have been destroyed and cannot be reconstructed.

_____.

I have had the informed consent discussion with my operating practitioner and I give my consent for this procedure. I have had the opportunity to ask questions of the operating practitioner that have been answered to my satisfaction.

Signed by _____ Date: _____ Time: _____

☐ Patient ☐ Parent / Guardian / Conservator ☐ Representative (specify): _____

Obtained / Acknowledged by:

_____ Date: _____ Time: _____

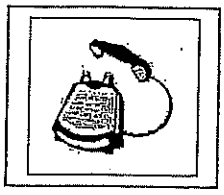
Signature, date, and time is required for all consents.

Limited English Proficiency – to obtain consent in any UCHC location from this patient with LEP:

☐ Live qualified interpreter was used ☐ Language Line operator / interpreter (# _____) was used

Name of Interpreter: _____

Telephone Consent Only



Consent via telephone requires the name of the person providing consent and their relationship to the patient and a witness other than the practitioner obtaining consent.

Obtained from: _____

Relationship to patient: _____

Obtained by (print name): _____

Obtained by (signature): _____

Witness: _____

Date: _____ Time: _____

University of Connecticut
Health Center
John Dempsey Hospital

(Patient Identification)

Authorization for Transfusion of Blood or Blood Components

1. My practitioner (physician, Advance Practice RN or Physician Assistant) has told me that a transfusion of blood and/or one of its components (i.e. plasma, platelets) is and/or potentially may become medically indicated as a part of my care.

2. My practitioner has told me the reasons why a transfusion is and/or potentially may become medically indicated. For example, red blood cells carry oxygen to body tissues and platelets help to clot my blood. I may need a transfusion because I need to replace blood I have lost. I also may need a transfusion because my body cannot make the blood cells I need. There may be other potential benefits as well.

3. My practitioner has told me about the known risks involved in receiving a transfusion. I have been told that blood used at the UConn Health Center is tested for many infectious diseases. Even though this testing is done, I also have been told that there is still a very small chance that I could get an infectious disease from an unknown, unusual or unanticipated pathogen after a transfusion.

4. My practitioner has told me that there are other known risks associated with receiving a transfusion. **Occasionally, people develop fever, chills, and allergic-reactions like hives. Infrequently, patients may develop heart failure. On rare occasions, patients have experienced damage of red blood cells, shock, and chest pain or I could even die because of a transfusion.** These reactions are very uncommon but rarely do occur absent prior indication and/or warning.

5. If medically necessary, I may be given other medicines before, during, and/or immediately after a transfusion. These medicines are intended to stop or reduce my reaction to a transfusion.

6. My practitioner has also told me about alternative forms of treatment other than transfusions where they are known to exist.

7. Unless there are other developments in my condition or a new risk is identified to the blood supply during this period that must change my consent, it is valid as described below. If my condition changes or there is a new risk to the blood supply, I will be given new or additional explanation by my practitioner.

   - Consent obtained during my inpatient stay is valid throughout my admission.
   - Consent obtained before my scheduled ambulatory procedure or my admission for an inpatient procedure is valid until I am discharged.
   - Consent obtained for my outpatient treatment that is expected to include multiple visits for my given condition is valid for a period of 6 months from the date of my signature below.

I have read this form or it has been read to me. The information has been explained to me and I understand its meaning. My practitioner has given me a chance to ask any and all questions about blood transfusions. I give my permission for transfusion to be performed as ordered by or on behalf of my practitioner.

Signed _____ Date: _____ Time: _____

☐ Patient ☐ Parent/Guardian/Conservator ☐ Representative (specify): _____

Signed _____ Date: _____ Time: _____

☐ MD ☐ APRN ☐ PA

Limited English Proficiency – to obtain consent in any JDH location from this patient with LEP:
☐ Live qualified interpreter was used ☐ Language Line operator /interpreter (# _____) was used

Telephone Consents: Witness _____ Date: _____ Time: _____

INFORMED REFUSAL OF TRANSFUSION

1. I choose to refuse a blood transfusion of blood and all blood products made from blood. My doctor has told me the reasons why a transfusion is medically indicated for my treatment. **I know that refusing a transfusion may make me sicker and that I may die.**
2. This decision is my own. I do not hold the doctors, employees, agents, directors or officers at the University of Connecticut Health Center responsible for respecting my wish not to accept blood transfusions or other blood products.
3. I have read this form or it has been read to me. The information has been explained to me and I understand its meaning.

Signed _____ Date: _____ Time: _____

☐ Patient ☐ Parent/Guardian/Conservator ☐ Representative (specify): _____

Witness _____ Date: _____ Time: _____

WHITE – Medical Records YELLOW – Blood Bank

If you are going to have a procedure, please read the information below and keep these pages for use before and after hospitalization using our website:

As a person with pain, you have the right to:

- Information about pain and pain relief measures
- Have your report of pain taken seriously and to be treated with dignity and respect by your care providers
- Have your pain thoroughly assessed and promptly treated
- Be informed by your care provider about what may be causing your pain, possible treatments, and the benefits, risks, and costs of each
- Participate actively in decisions about how to manage your pain.
- Have your pain reassessed regularly and your treatment adjusted if your pain has not been eased.
- Get clear and prompt answers to your questions.
- Have time to make decisions.
- Accept or refuse any treatment, such as medications, tests, and procedures, including the right to refuse pain medications.
- Be referred to a pain specialist if your pain persists.
- An appropriate pain management plan to use at home.

As a person with pain, you have the responsibility to:

- Ask your care provider what to expect regarding pain and pain relief options.
- Ask for pain relief when pain first begins.
- Help your care providers assess your pain and tell them if the pain is not relieved.
- Tell your care providers about any worries you have about taking pain medication.
- Tell your care providers if you have side effects.
- Be open and honest with your care provider.
- Ask questions, keep notes and write them down.
- Have your pain medication prescriptions written by a single care provider and filled at one pharmacy.
- Request refills with at least 48 hours notice before running out.
- Make sure you understand the dose and dosing instructions. If you do not, we rely on you to ask.

At UConn Health, we've taken surgery to a new level. The UConn Health Surgery Center is a state-of-the-art facility designed exclusively for your safety and comfort. For all its advanced technology and high quality care, the Surgery Center is a warm, friendly place where your health and well-being are our main priority.

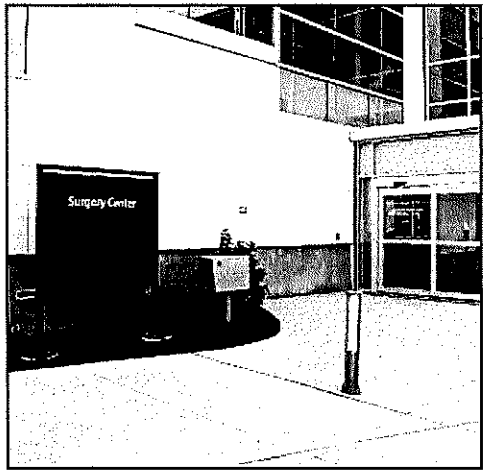
The first steps to a successful surgery are yours. Follow these guidelines on the days before your surgery.

- One to three days before surgery, expect a five-to-ten minute phone call from the Surgery Center nurse. Have a pen and paper ready. She will review your medical history, surgical instructions, and medication list.
- Follow your surgeon's instructions about taking routine medications.
- Make arrangements for a responsible adult, over the age of 18, to accompany and stay with you for 24 hours after surgery.
- You will be called with your arrival time after 2 p.m. the last working day prior to your surgery.

For further information, call **860.679.6000**.

From the Farmington Avenue entrance, proceed on Main Road to the roundabout and follow the signs to the Surgery Center and Parking Garage 1. The entrance to the UConn Health Surgery Center is on level 2. Patient and visitor parking is also available on level 2.

Visit **health.uconn.edu** for further directions.



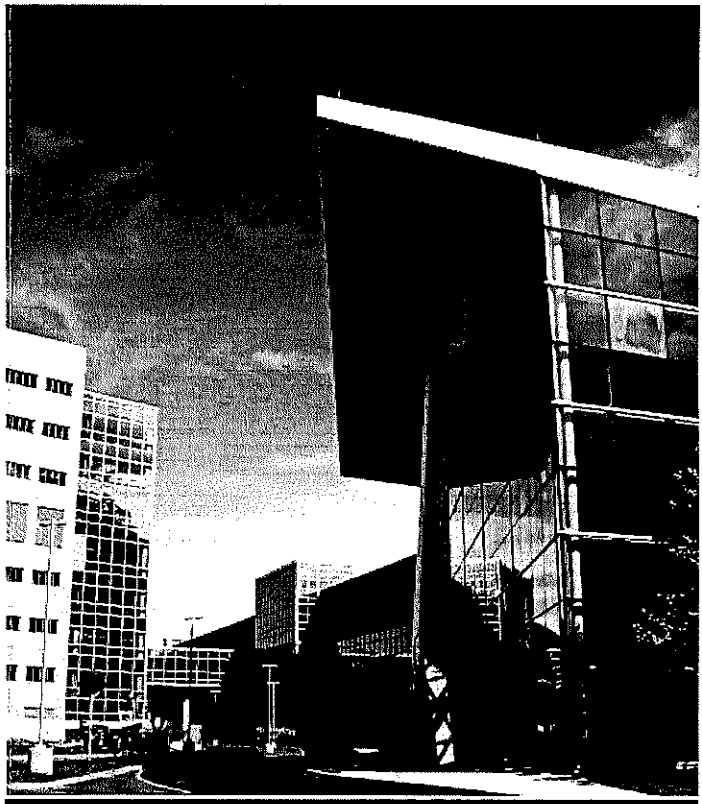
Entrance to UConn Health Surgery Center.

UCONN HEALTH
THE POWER OF POSSIBLE.

263 FARMINGTON AVENUE
FARMINGTON, CT 06030
health.uconn.edu

Your Guide to Surgery

UConn Health Surgery Center



UCONN HEALTH

THE POWER OF POSSIBLE.

Day of Surgery

Follow these simple rules to make the day of your surgery safer and more comfortable.

- Do not eat or drink after midnight (unless otherwise directed). This includes mints, lozenges, or gum.
- Bring a list of medications with dosage and frequency information.
- Bathe or shower on the day of surgery.
- Brush your teeth but do not swallow any liquid.
- Do not use makeup, hair spray, lotions, or oils.
- Remove all body piercings.
- Wear loose, comfortable clothing and shoes.
- **Leave all jewelry and other valuables at home.**
- Bring all sensory/assistive devices including glasses and hearing aids. Remove contact lenses at home.
- If indicated, you must provide guardianship paperwork and/or power of attorney documents. The surgery will be canceled if these legal documents are not available.
- The anesthesia team will be available to discuss anesthesia options and answer any questions.
- Bring a photo I.D.
- Do not bring children with you on the day of your surgery.

If you are having day surgery:

- **Whether you are driving in a car, taking a cab or other public transportation; a responsible adult, over the age of 18, must accompany you and stay with you for 24 hours or your surgery may be canceled.**

If you are being admitted to the hospital:

- Contact the hospital floor for the visitor's policy including child visitor restrictions.
- You should anticipate leaving at 11 a.m. on the day your doctor discharges you from the hospital.

We recommend two adults accompany a child: one to drive, and one to provide care.

- Please leave all siblings, other family and friends at home.
- Bring your child a change of clothing.
- Talk to your child about the surgery and what they can expect.
- Encourage your child to ask questions.
- Bring your child's favorite toy or blanket.
- You can stay with your child until they are taken to the operating room. You will be reunited as soon as possible after surgery.

Contact your surgeon's office with any questions regarding your surgical procedure.

Pediatric tours are available in advance upon request. Please call **860-679-6000** to schedule an appointment.

Your surgery and anesthesia charges will be billed to your insurance company. You are responsible to pay any balance as per your individual insurance policy.

If your surgery is not covered by insurance, you are required to pay on or before the day of surgery. An actual bill indicating a total charge will be sent after surgery. Unpaid balances must be paid within 30 days. All major credit cards are accepted.

If you have any questions regarding your insurance or billing, please call us at **860.679.1600**.