Children's National

111 Michigan Ave NW
Washington, DC 20010

Surgeon's office to complete the following:
Fax completed form to: _____ *Date of surgery :* _____

Contact your surgical scheduler or surgeon's office if the following:
Wheezing/cough in the past week Recent fever > 100.7°F or 38°C Pneumonia/flu in the prior 4 weeks

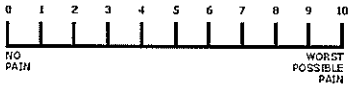
Surgical History & Physical - Interdisciplinary Patient Assessment

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: _____ Duration: _____ Frequency: _____ 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: _____

Past Medical (select if patient has or has had):

Asthma/Reactive Airway Disease	□ Yes	□ No	Congenital Heart Disease	□ Yes	□ No
Tracheostomy	□ Yes	□ No	Heart Murmur	□ Yes	□ No
Bleeding Disorder/Tendency	□ Yes	□ No	GERD	□ Yes	□ No
Allergies/Reactions	□ Yes	□ No	Prematurity	□ Yes	□ No
Genetic Disorder	□ Yes	□ No	Renal Disease	□ Yes	□ No
Neurologic Disorder	□ Yes	□ No	Family h/o Anesthesia Problem	□ Yes	□ No

Other/Describe Positive: _____

Surgical History: _____
Family History/Psychosocial Assessment: _____
Immunizations Up To Date: Yes No **Date of Last Menstrual Period** _____ N/A_____

Current Medications & Dose: _____
_____
_____
_____

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:

□ General Appearance (State) _____

□ Head / Fontanel _____

□ Ears _____

□ Eyes _____

□ Nose _____

□ Mouth / Teeth / Pharynx _____

□ Lymph Nodes _____

□ Abdomen _____

□ Genitals _____

□ Anus / Rectum _____

□ Skin / Scalp _____

□ Neurological _____

□ Skeletal (Back, Hip, Extremities) _____

□ Development / Growth _____

□ Other, describe _____

Labs / Radiology (if pertinent):_____

_____

Assessment (Medical /Surgical Indications for Admission):_____

_____

_____

Plan: _____

_____

(Mandatory) Education: □ Diagnosis, medications, & treatment plan discussed and reviewed with patient / family.

I certify that I have examined this patient and the patient is medically cleared for surgery:

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

Date: _____ Time:_____

Surgical Attestation: I have confirmed the history and physical as documented and examined the patient. The indications for surgery remain unchanged (any changes have been documented).

Surgery Attending Signature: _____ Date: _____ Time:_____

Print Name: _____

24 Hour Update: I have seen and examined this patient, concur with the documented history, physical examination, assessment and plan.

Surgery Attending Signature: _____ Date: _____ Time:_____

Print Name: _____

HNP