PLEASE BRING WITH YOU TO THE SURGERY CENTER
ON THE DAY OF SURGERY

PATIENT ACCOMPANIMENT UPON DISCHARGE ADVISEMENT

For patient safety, you are hereby advised that it is the policy of Specialty Surgical Center ("SSC") that all patients who receive medical services, requiring anesthesia, be discharged in the company of an adult friend or family member "responsible adult sponsor".

SSC will make every attempt to accommodate your scheduling needs in order to ensure that you have a responsible adult sponsor to accompany you home following discharge.

Please be advised that if you arrive for your scheduled surgery and are not willing or able to provide the name and telephone number of a responsible adult sponsor to accompany you home following surgery, your surgery will be rescheduled to another date.

____________________________ ____________________________

RESPONSIBLE ADULT SPONSOR NAME CONTACT NUMBER(S) AND/OR LOBBY

I HAVE RECEIVED, READ AND UNDERSTAND THIS PATIENT ACCOMPANIMENT UPON DISCHARGE ADVISEMENT.
I HAVE RECEIVED PRE-OPERATIVE INSTRUCTIONS REGARDING MY PROCEDURE PRIOR TO MY ADMISSION.

____________________________ ____________________________

BEST NUMBER FOR POST-OP CALL PERMISSION TO LEAVE MESSAGE PT SIGNATURE

PATIENT SELF ASSESSMENT

Please fill out and hand to the receptionist when completed. The information on this sheet will be discussed with the nurse upon admission.

ALLERGIES to Drug/Medication (if Any): Allergic to Latex (Circle Yes or No): Yes No

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HEIGHT: ____________ **WEIGHT:** ____________

Name of Your Primary Care Physician or Internist

____

List medications you take currently **(including aspirin, natural herb supplements, diet pills)**:

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____

List previous surgeries or procedures **(including childhood)**:

____

____

PAST OR PRESENT HEALTH HISTORY (Circle Yes or No)

Health Issue		Explain	Health Issue			Explain
High Blood Pressure	Yes No		Arthritis		Yes No	
Stroke	Yes No		Headaches		Yes No	
Alcohol / Recreational Drug Use & Qty/Day			Pregnant		Yes No N/A	LMP:
Smoking - Time of Last	Yes No		Thyroid Disorder		Yes No	
Lung Disease	Yes No		Past Anesthesia Problems		Yes No	
Sleep Apnea	Yes No		Prosthesis / Implant / Pacemaker		Yes No	
Heart Disease	Yes No		Bleeding Disorder		Yes No	
Mitral Valve Prolapse	Yes No		Seizure Disorders		Yes No	
Liver Disease	Yes No		Diabetes		Yes No	
Kidney Disease	Yes No		Recent Cold / Flu / Infection		Yes No	
Cancer	Yes No		Other			

____________________________ ____________________________

PATIENT SIGNATURE DATE

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IF SIGNED BY OTHER THAN PATIENT, INDICATE RELATIONSHIP

DISCHARGE ADVISEMENT AND SELF ASSESSMENT

Patient Label Here