Fit for Surgery Center
NavicentHealth

Pre-Admission Testing & Fit for Surgery Screening Tool

Name: _____ Contact #: (H) _____ (C) _____

Date of Birth _____ Surgeon: _____ Surgery Date _____

Please answer the following questions:

1. Have you ever had heart problems? ☐ *Yes ☐ No
   ☐ Chest Pain ☐ Heart Failure ☐ Irregular Heart Rhythm ☐ Heart Attack ☐ Heart Surgery
   ☐ Aortic Aneurysm ☐ Heart Valve Replacement
2. Do you have high blood prssures? ☐ Yes ☐ No Take blood pressure medication? ☐ Yes ☐ No
3. Do you use: ☐ *home oxygen ☐ *CPAP/BiPap ☐ *Inhaler/Nebulizer more than 2 times per week
4. Do you have: ☐ *COPD ☐ *Emphesema ☐ *Asthma ☐ *Sleep apnea or been told you may have sleep apnea
5. Do you have: ☐ *Wheezing ☐ *Shortness of Breath at rest ☐ *Shortness of breath with mild activity
6. Do you have to stop and rest when walking up a flight of stairs? ☐ *Yes ☐ No
7. Do you smoke OR use tobacco? ☐ Yes ☐ No
8. Do you have diabetes? ☐ *Yes ☐ No Take medication for diabetes? ☐ Pills ☐ Insulin ☐ Insulin Pump
9. Do you take prescription blood thinner? ☐ *Yes ☐ No (Plavix/Coumadin/Xarelto/Pradaxa/Eliquis, etc.)
10. Do you: ☐ *have a bleeding disorder ☐ bleed easily or have trouble stopping bleeding
11. Do you have: ☐ *Chronic kidney disease ☐ *Decreased kidney function
12. Are you on dialysis? ☐ *Yes ☐ No ☐ Hemadialysis ☐ Peritoneal dialysis
13. Do you have: ☐ *Liver disease ☐ *Cirrhosis ☐ *Hepatitis
14. Have you ever had a blood clot in the log or lung? ☐ Yes ☐ No
15. In the past year, have you had a: ☐ *Stroke ☐ *Mini-stroke
16. Do you have a peripheral vascular or arterial disease? ☐ *Yes ☐ No
17. Have you: ☐ had a seizure in the past 6 months? ☐ Do you take anti-seizure medication?
18. Do you take prednisone or steroids? ☐ Yes ☐ No
19. Do you take medication for Rheumatoid Arthritis? ☐ Yes ☐ No
20. Have you had any problems with anesthesia such as
    ☐ difficult intubation ☐ *high temperature after anesthesia (malignant hyperthermia)
    OR ☐ have a family history of malignant hyperthermia
21. Do you have a past OR current history of ☐ *drug abuse ☐ *alcohol abuse
22. Have you spent one or more nights in the hospital in the last 3 months? ☐ *Yes ☐ No
23. Have you ever been diagnosed with a MRSA or VRE infection? ☐ Yes ☐ No

Any YES answer to the questions above indicates a patient requires a Face to Face PAT visit.

Criteria for optional referral to Fit for Surgery Clinic
1. **Patient marks any box with an "*"**
2. **Patient marks YES to any two questions**

All NO answers to the questions above indicate the patient may be eligible for phone screening.

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