How to Prepare for Your Surgery

St. Thomas Elgin General Hospital

Patient Name: _____ Surgeon: _____

Procedure: _____ Date of Surgery: _____

*****Failure to follow these directions may result in cancellation of your surgery*****

Due to ongoing precautions regarding the Covid-19 Pandemic , you will be required to self-isolate at home for 14 days prior to your surgical procedure

The Night Before Surgery

- Follow any dietary instructions given by your surgeon for the days leading up to your surgery
- You may have clear fluids up until _____ before your surgery
  - Clear fluid options: black tea, black coffee, apple juice, water, gingerale, Gatorade (NOT orange juice)
- DO NOT eat solid food or have candy after midnight
- DO NOT add milk, cream or powder to your black coffee or tea
- DO NOT drink alcohol
- DO NOT smoke for 24hrs before surgery
- DO NOT smoke marijuana for at least 48hrs before surgery

The Morning of Surgery

- Continue prescription medications unless your surgeon/anesthesiologist/Family Doctor has asked you to stop
- Shower or bathe and brush your teeth
- DO NOT shave the operative area
- Wear comfortable, loose fitting clothing
  - Cataract patients: wear a short-sleeved, button-up shirt
- DO NOT wear perfume, makeup, aftershave, cologne, deodorant or nail polish
- REMOVE all jewelry and piercings prior to coming to the hospital
- DO NOT bring valuables to the hospital
- Bring your valid health card and have it readily available when you check in
- Bring your completed Patient Worksheet

YOU MUST HAVE A RESPONSIBLE ADULT TO DRIVE YOU HOME AND STAY WITH YOU FOR 24HRS AFTER SURGERY

Visitor Policy

Due to Covid-19 pandemic, STEGH has implemented restrictions on visiting in order to protect our patients and staff.

ADULT Patients- 1 person as a caregiver, interpreter. PEDIATRIC, C-SECTION- one parent for children under 18 and 1 support person for C-sections

Pre-Admission Appointment Required: ☐ yes ☐ no

If required, you will receive this appointment from your surgeon when your surgery is booked. Please bring your ***medications in their original containers, a list of your medications***, your Health Card and paperwork from your surgeon to this appointment.

☐ In person at STEGH

☐ Telephone appointment

Date and Time:

_____

Failure to keep your Pre-Admission Appointment may lead to cancellation of your surgery.

If you need to rebook/cancel your Pre-Admission appointment, call 519-631-2030 ex. 3131 as soon as possible. Booking hours are: Monday-Friday from 07:30am to 3:30pm

Cumulative Patient Profile Required: ☐ yes ☐ no

If "yes" is checked above, you will need to call your primary care provider's office to request that a copy of your CPP is faxed to the hospital prior to surgery (fax to 519-631-5325) or brought with you to your Pre-Admission appointment (if you have one) or on the day of surgery.

You may need to contact your primary care provider to get recommendations about which medications to take prior to surgery, unless otherwise instructed by your surgeon or anesthesiologist.

Additional Appointments

Internal Medicine Consultation ☐ yes ☐ no Date and Time: _____	Anesthesia Consultation ☐ yes ☐ no Date and Time: _____

Confirmation of Arrival Time

You will be notified by the hospital of your arrival time around 72 hours before your scheduled surgery. Please do not call in. Thank you.

Packing for Your Hospital Stay

One Day Stay

If you are having your procedure done and leaving hospital on the same day, you need to bring:

- Current medications in their original containers
- Eyeglasses or contact lens case
- Information package from your Preadmission appointment

Same Day Admission

If you are staying overnight after your procedure, bring everything listed above AND:

- Toiletry items (toothbrush/paste, deodorant)
- Sleep apnea machine and equipment
- Non-slip footwear
- Walking devices (walker, cane)

What to Expect After your Surgery

If you are going home the same day as your surgery, you will be discharged from the Outpatient Surgery Department. The side effects of anesthesia may last for some time after you are awake and ready to go home. You MUST have a pre-arranged responsible adult to drive you home and stay with you for 24hrs after surgery

For the next 24hrs, you:

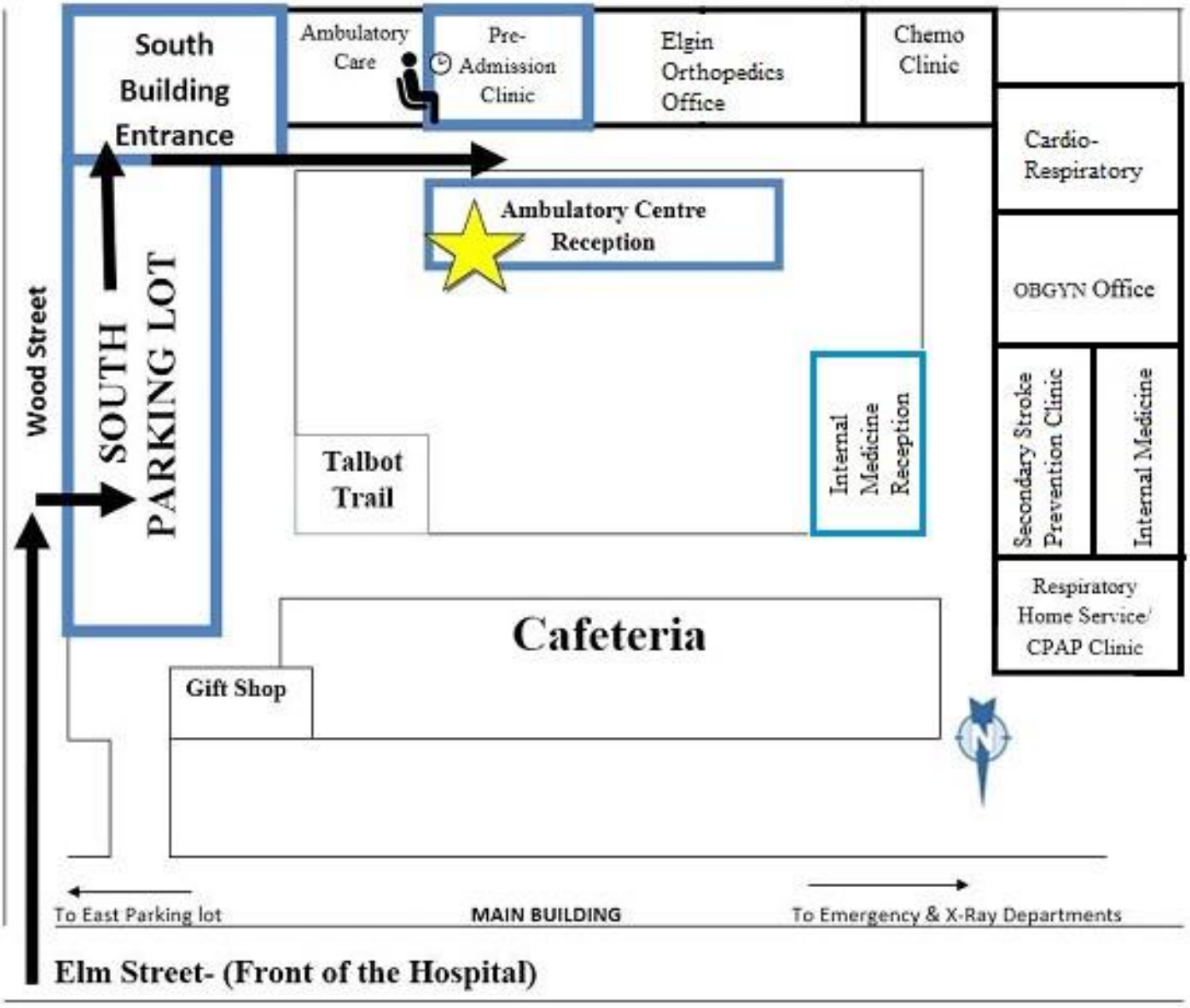
- Should not drive or operate heavy equipment
- Should not smoke or drink alcohol
- Should not make important decisions or sign legal papers
- May have muscle stiffness, dizziness, sleepiness or feel lightheaded
- May have a sore throat for up to 48hrs

You will be given special instructions about how to care for yourself after you go home

STEGH is a scent-free facility. Please ensure that anyone who will visit you in hospital is aware of this.

St.Thomas Elgin General Hospital

Adult Pre-Admission Parking & Check In Directions



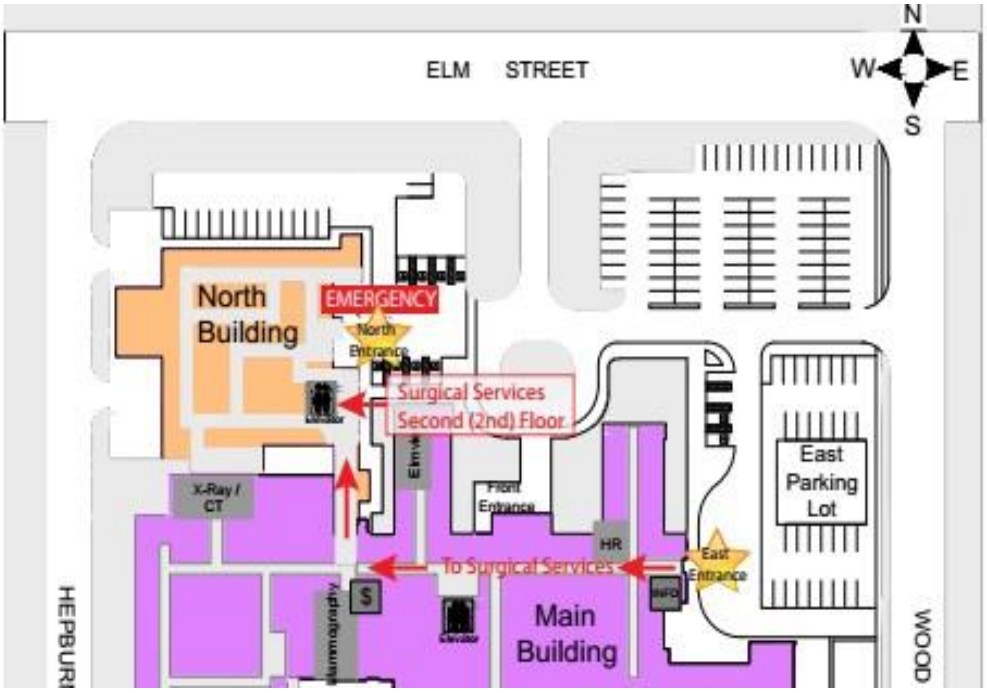
Adult and Paediatric Pre-Admission Patients

1. **Please park in the South Parking lot accessible from Wood Street.**
2. **Enter the "South Building Entrance" door.**
3. **Check in with Ambulatory Centre Reception for your appointment.**
4. **After hours patients (4:00 p.m. - 8:00 p.m.):**
5. **Please have a seat in the pre-admission waiting area**
   the nurse will call you in for your appointment.

Adult & Paediatc Day of Surgery
Parking& Check In Direction

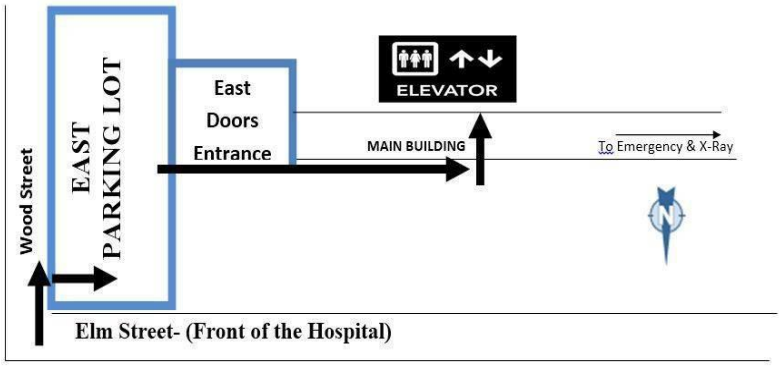
Adult and Paediatric Patients Arrival on the Day of Surgery

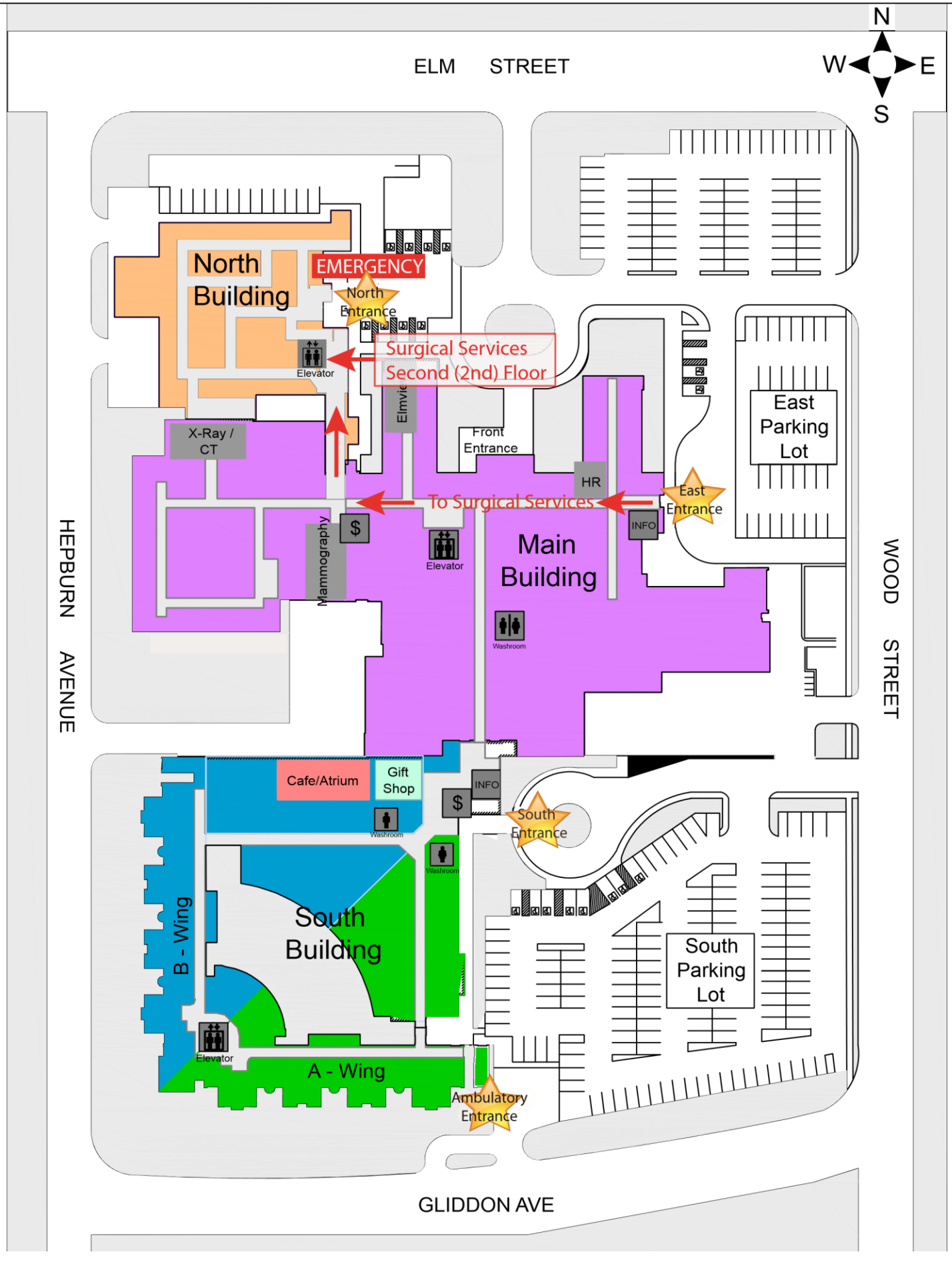
1. **Please park in the East Parking lot accessible from Elm or Wood Street.**
2. **Enter the North Building on the Ground Floor (under red Emergency sign, use the double sliding doors to the left).**
3. **Use the elevator to 2nd Floor.**
4. **Check in with staff in the Surgical Reception Office directly in front of you as you exit the elevator.**



Obstetrical C-Section Patients
Instructions for Pre-Admission Appointment and the Day of Surgery

1. **Please park in the East Parking lot accessible from Wood Street.**
2. **Enter the "East Door Entrance".**
3. **Continue straight down the corridor to the elevators on the left hand side.**
4. **Take elevator to 3rd Floor.**
5. **Report to the Nurses Station on the Woman & Children's Unit - directly across from the elevators.**




N
W
E
S
ELM STREET
HEPBURN AVENUE
WOOD STREET
GLIDDON AVE
North Building
EMERGENCY
North Entrance
Elevator
Surgical Services
Second (2nd) Floor
X-Ray / CT
Elmvie
Front Entrance
East Parking Lot
HR
East Entrance
To Surgical Services
INFO
Mammography
$
Elevator
Main Building
Washroom
Cafe/Atrium
Gift Shop
INFO
$
South Entrance
Washroom
Washroom
B - Wing
South Building
South Parking Lot
Elevator
A - Wing
Ambulatory Entrance

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CONSENT TO TREATMENT

EXPLANATION FOR USE REFER TO CONSENT TO TREATMENT POLICY

The signing of this consent is a necessary part of the health care service provided to the patient. It shall be used in the case of an operative,diagnostic or treatment/procedure where the Health Practitioner is of the opinion such consent should be obtained or where the hospital policy so requires. The nature, effect, purpose and material risks (including special and unusual risks) of the operative, diagnostic, or treatment / procedure must be explained to the patient by the Health Practitioner proposing or performing treatment.

SECTION A: SURGICAL OPERATION, PROCEDURE, or DIAGNOSTIC TEST

I, _____,
(NAME IN FULL OF PATIENT OR SUBSTITUTE DECISION MAKER)

the _____ of _____,
(RELATIONSHIP TO PATIENT) (NAME OF PATIENT)

have had the nature of the proposed treatment explained to me along with the expected benefits of that treatment. I have been advised of the risks and side effects of the proposed treatment as well as other courses of treatment available to me. I have been informed about the likely consequences of not proceeding with the proposed treatment. I have had opportunity to ask questions about the proposed treatment and any further/alternatives procedures considered necessary or on an emergency basis and have had my questions answered to my satisfaction. I understand the information provided to me. I give consent to the following treatment which may/may not require anesthetic:

_____,
(SURGICAL OPERATION, PROCEDURE, OR DIAGNOSTIC TEST)

to be performed by _____ and his or her team.
(NAME OF HEALTH PRACTITIONER)

_____ **Initials** I understand that any tissues/organs removed from me/this patient may be retained and used for the purposes of diagnosis/care and will be disposed of by the hospital based on standards governing the disposal of such material.

Transfusion of Blood and/or Blood Products

To be completed only if transfusion of blood and/or blood products is expected or required. Blood products include, but are not limited to: red blood cells, plasma, platelets, albumin, factor concentrates, immune globulins.

_____ **Initials** **I, consent** to the transfusion of blood and/or blood products if required. I have been given information on transfusion of blood and/or blood products. I have had an opportunity to discuss alternatives, risks and benefits to transfusion.

OR

_____ **Initials** **I, refuse** the transfusion of blood and/or blood products. I've completed the Refusal /Consent with Restrictions of Blood and/or Blood Products form.

I DECLARE THAT I HAVE READ THIS CONSENT TO SURGICAL OPERATION, PROCEDURE OR DIAGNOSTIC TEST, OR IT HAS BEEN READ OR EXPLAINED TO ME AND I FULLY UNDERSTAND IT.

_____	_____	_____
(Date YYYY/MM/DD)	(Signature of Patient or Substitute Decision Maker)	(Signature of Witness)

SECTION B - TELEPHONE CONSENT

The foregoing consent of _____ was given by _____
(Print patient name) (Print name of person giving consent)

telephone by _____ in the presence of _____
(Print name of Health Practitioner) (Print name of witness)

at the St.Thomas Elgin General Hospital on the day above mentioned. (The circumstances to be fully described in the Medical Record)

_____ _____ _____ _____
(DateYYYY/MM/DD / Time) (Signature of Health Practitioner) (Signature of Witness-Registered Health Care Provider)

SECTION C - EMERGENCY CONSENT

I hereby certify that in my opinion the delay necessary to obtain the written consent of or on behalf of

_____ would endanger the patient's life or limb or a vital organ. The
(Patient's name)

circumstances to be fully described in the Medical Record.

Procedure or Surgical Operation to be performed:_____

_____

_____ _____ _____
(Date YYYY/MM/DD / Time) (Signature of Health Practitioner)

SECTION D - TREATMENT IN CANADA FOR U.S.A. AND OTHER FOREIGN RESIDENTS

Complete this section if the patient receiving treatment lives outside of Canada.

I,_____, agree that the relationship between myself and
(Name of patient or substitute decision maker)

_____ shall be governed by and constructed in accordance with the law
(Name of Health Practitioner)
of the Province of Ontario.

I,_____, acknowledge that the treatment/service is to be
(Name of patient or substitute decision maker)

performed in the Province of Ontario, and that the Courts of the Province of Ontario shall have jurisdiction to entertain any complaint, demand, claim or cause of action whether based on alleged breach of contract or alleged negligence arising out of treatment. I hereby agree that I will commence any such legal proceedings in the Province of Ontario, and only in the Province of Ontario,and hereby submit to the jurisdiction of the courts of the Province of Ontario.

_____ _____ _____
(Date YYYY/MM/DD) (Name of Patient or Substitute Decision Maker) (Signature of Health Practitioner)

St.Thomas Elgin General Hospital

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PRE-OPERATIVE / PRE-PROCEDURAL PATIENT WORKSHEET

Thank you for taking the time to complete this worksheet as thoroughly as possible to ensure our Team has your important health information when you present to your **Preadmit appointment**.

Patient or designate MUST complete this form prior to the appointment. Please bring this **completed worksheet** along with your prescription(s) and any over the counter medication (ie: vitamins, supplements, herbals etc.) in their original containers.

INSTRUCTIONS: Please read all questions carefully and respond by placing a check (✓) in the "yes" or "no" box. For a "yes" response provide additional information in the "describe" section, including the date the problem was diagnosed and any medications, treatments, or hospital stays you have required for the problem.

PRE-OPERATIVE / PRE-PROCEDURAL QUESTIONS	YES	NO	DESCRIBE
Do you have high blood pressure?			
Do you have any heart problems? (e.g. heart attack, murmur, angina, blockages, angioplasty, stent, valve problems, irregular heartbeat, pacemaker, heart surgery, or heart failure)			
Have you ever had heart failure or fluid in your lungs?			
Do you have an implantable cardiac defibrillator?			
Have you ever been treated for an irregular heart beat?			
Does climbing one flight of stairs or walking one city block make you short of breath or give you chest pain?			
Do you have asthma?			☐ Use Inhalers Regularly ☐ Use Inhalers Occasionally ☐ On Prednisone
Do you cough frequently or have bronchitis or emphysema?			
Do you smoke cigarettes?			
Do you have sleep apnea? If yes, do you use CPAP?			
Do you have liver disease, or a history of jaundice or hepatitis?			
Do you drink more than three drinks of alcohol per day? If yes, how many per week? _____			
Do you have indigestion, heartburn, or a hiatus hernia?			
Do you have a history of thyroid problems?			
Do you have diabetes?			☐ Diet Controlled ☐ On Pills ☐ On Insulin
Do you have a kidney problem? If yes, have you every required dialysis?			
Do you have numbness or weakness of your arms or legs?			
Have you had epilepsy, blackouts, seizures or a stroke?			

PRE-OPERATIVE / PRE-PROCEDURAL PATIENT WORKSHEET

PRE-OPERATIVE / PRE-PROCEDURAL QUESTIONS	YES	NO	DESCRIBE
Have you ever had problems with blood clots, or excessive bleeding?			
Do you have any other important medical problems? Please List			
Have you ever had an anaesthetic ? If yes, have you had any problems with anaesthetic ?			
Has your health changed since your last anaesthetic?			
Have you or any member of your family had a reaction to an anaesthetic or the placement of the breathing tube?			
Do you have neck or jaw pain or arthritis?			
Do you have dentures, capped or loose teeth?			
Is there any possibility you may be pregnant?			
Have you taken prednisone, steroid medication, or cortisone-like drugs in the past year?			
Would you refuse a blood transfusion as a life-saving procedure?			

Please list any operations you have had in the past:

Please list any food or medication allergies (including latex) that you have:

MEDICATION LIST: (prescription and over the counter medication including vitamins, supplements, herbals, rubs, etc.)

Name of Medication	Dose	How much?	When Taken	**Take morning of Surgery?
Example: Aspirin	10 mg	1 tab	twice daily	☐
1.				☐
2.				☐
3.				☐
4.				☐
5.				☐
6.				☐
7.				☐
8.				☐
9.				☐
10.				☐
11.				☐
12.				☐
13.				☐

**IMPORTANT; Have your Doctor check the box of each medication you are required to take with a sip of water early the morning of surgery.

Please Note: This is a worksheet that is to be completed by the patient or designate. Information contained in this document will be reviewed during the patient's appointment and electronically charted in the Electronic Patient Record (Cerner System).

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REFUSAL/CONSENT WITH RESTRICTIONS OF TRANSFUSION OF BLOOD AND/OR BLOOD PRODUCTS

Affix Patient Label

Name: _____

MRN: _____ D.O.B: _____

Provider: _____ Procedure Date: _____

Refusal/Consent with restrictions of transfusion of Blood and/or Blood Products

I, _____,
(Name in full of patient or Substitute Decision Maker)

the _____ of _____.
(Relationship to Patient if Substitute Decision Maker) (Name of Patient)

understand that I may require transfusion of blood and/or blood products during the course of my medical/surgical treatment. I have had the nature of the proposed transfusion explained to me along with expected benefits. I have been advised of the risks and side effects of the proposed blood/blood product transfusion as well as alternative courses of treatment available to me. I have been informed that the consequences and risks, including death, of not proceeding with the proposed transfusion. I have had opportunity to ask questions about the proposed transfusion and have had my questions answered to my satisfaction. I understand the information shared with me.

Refer to page 2 for description of Blood/Blood Products

BLOOD / BLOOD PRODUCTS		
Predonated Autologous Blood	☐ Accept	☐ Refuse
Allogeneic Blood	☐ Accept	☐ Refuse
Red Cells	☐ Accept	☐ Refuse
Plasma	☐ Accept	☐ Refuse
Platelets	☐ Accept	☐ Refuse
Cryoprecipitate	☐ Accept	☐ Refuse
Albumin	☐ Accept	☐ Refuse
Immune Globulins	☐ Accept	☐ Refuse
Blood-derived clotting factors	☐ Accept	☐ Refuse
Medicines which include minute amounts of albumin in their formulation	☐ Accept	☐ Refuse

I refuse the transfusion of all blood and/or blood products. I hereby release St. Thomas Elgin General Hospital (STEGH), its directors, officers, employees, independent health practitioners, including physicians with privileges at STEGH, from all liability related to negative outcomes, complications or unfavourable results, including death, that occur as a result of my refusal of the use of blood and/or blood products.

_____ _____.
(Date YYYY/MM/DD) (Signature of Patient or Substitute Decision Maker)

DESCRIPTION OF BLOOD PRODUCTS

Predonated Autologous Blood

Arrangements are made with the Canadian Blood Services to collect autologous blood (patient's own blood). It is tested the same as allogeneic blood, and then separated into red cells and plasma. The plasma is discarded unless specifically requested by the treating physician, and the red cells are stored to a maximum of 42 days. If this blood is not transfused to the patient, it is discarded.

Allogeneic Blood

Blood is donated by healthy volunteer donors at the Canadian Blood Services where it is separated into red blood cells, plasma, platelets and sometimes cryoprecipitate.

All blood must test negative for antibodies to HIV-1 /HIV-2, HCV, HTLV-I/II and HBcore antigen. It must also test negative for the presence of viral RNA to HIV-1, HCV and WNV as well as negative for HBsAG and syphillis.

Red Cells

Red cell concentrate (packed red cells) are prepared at the CBS from approximately 480mL whole blood collected in 70mL of CPD anticoagulant. The unit is plasma reduced by centrigugation, and leukoreduced by filtration. Red blood cells are resuspended in approximately 110mL of SAGM nutrient for a hematocrit of approximately 60%.

Plasma

Plasma is collected from donors either as part of the whole blood collection or by apheresis. It is frozen by the CBS and remains frozen until required. It is then thawed by the Blood Transfusion Lab.

Platelets

Platelets are collected from donors either as part of the whole blood collection or by apheresis. 4 whole blood platelet concentrates are pooled to make 1 adult dose. Platelets are leukoreduced by either filtration or by apheresis.

Cryoprecipitate

Cryoprecipitate is prepared from slowly thawed plasma that has been centrifuged to separate the insoluable portion of the plasma. It contains fibrinogen, Factor VIII and von-Willebrand's factor and is resuspended in about 5 - 15mL of plasma. It is then refrozen and thawed when required. Uusually 10 units of cryopreciptate are pooled in the Blood Transfusion Lab to make 1 adult dose.

Albumin

Albumin (25% and 5%) used for transfusion is made from human pooled plasma using a fractionation process to isolate the albumin portion of the plasma. A further viral inactibation step included heat treatment. (NOTE: Albumin is a protein that makes up about 4% of normal plasma)

Immune Globulins

Immune globulin is a concentrated solution of antibodies made from large pools of human plasma using a combination of fractionation, precipitation, filtration and anion-exchange chromatolgraphy. Processing also includes viral inactivation steps. There are general immune globulins such as Intravenous, Subcutaneous and Intramuscular Immune Globulin as well as specific preoparations including Rh Immune Globulin, Hepatitis Immune Globulin, Varicella-Zoster Immune Globulin. NOTE: Immune globulin is a protein that makes us about 3% of normal plasma)

Blood-derived clotting factors

This includes but is not limited to: Prothrombin Complex Concentrates (eg Octaplex, Beriplex), Humate-Pm FEIBA, Anti-Thrombin III, as well as C1 Esterase Inhibitor. These products are made from large pools of human plasma and include concentration steps as well as viral inactivation steps in the manufacturing process.

Most Factor VIII and IX products are recombinant clotting factors and do not use albumin as a stabilizer.

DDAVP is a synthetic anolog of human desmopressin. It does not contain albumin.

Medicines which include minute amounts of blood in their formation

Albumin may be used in the formulation of other medicines. It would be important to notify Pharmacy if patient refuses all medicines that contain albumin.

Opioid Pain Medicines

Information for Patients and Families

You have been prescribed an opioid pain medicine that is also known as a narcotic. This leaflet reviews some important safety information about opioids.

Patients, family, friends, and caregivers can play an important role in the safe use of these medicines; share this information with them.

With opioids, there is a fine balance between effective pain control and dangerous side effects.

Opioids are intended to improve your pain enough so that you are able to do your day to day activities, but not reduce your pain to zero. Be sure that you understand your plan for pain control and work closely with your doctor if you need opioids for more than 1-2 weeks.

Risk of overdose and addiction:
Many people have used opioids without problems. However, serious problems, including overdose and addiction, have happened. It is important to follow the instruction on the prescription and **use the lowest possible dose for the shortest possible time**, and to be aware of signs that you are getting too much opioid.

Avoid alcohol and benzodiazepines.

Side effects:
Constipation, nausea, dry mouth, itchiness, sweating, and dizziness can happen often with opioids. Contact your doctor or pharmacist if your side effects are hard to manage.

Your ability to drive or operate machinery may be impaired.

Some people are more sensitive to the side effects of opioids and may need a lower starting dose or more careful monitoring. Talk to your doctor about the HIGHER RISK of dangerous side effects if:

- You have certain health conditions, for example:
  - Sleep apnea
  - Lung disease (e.g. COPD or asthma)
  - Kidney or liver problems
- You have never taken opioids before
- You are already taking an opioid or medications for anxiety or to help you sleep
- You have a history of problems with alcohol or other substances
- You have had a bad reaction to an opioid before
- You are age 65 or older

Safe keeping:

Never share your opioid medicine with anyone else. Store it securely in your home. Take any unused opioids back to your pharmacy for safe disposal.

Ask your Pharmacist if you have any questions.

Other options are available to treat pain.

Signs of Overdose

Stop taking the drug and get immediate medical help if you experience the following:

- Severe dizziness
- Inability to stay awake
- Hallucinations
- Heavy or unusual snoring
- Slow breathing rate

Your family member or caregiver needs to call 911 if:

- You can't speak clearly when you wake up
- They can't wake you up
- Your lips or fingernails are blue or purple
- You are making unusual heavy snoring, gasping, gurgling or snorting sounds while sleeping
- You are not breathing or have no heartbeat

Never leave a person alone if you are worried about them.

Ask about take-home naloxone kits.

PATIENTS FOR PATIENT SAFETY CANADA | PATIENTS POUR LA SÉCURITÉ DES PATIENTS DU CANADA

cpsi icsp
Canadian Patient Safety Institute | Institut canadien pour la sécurité des patients

ismp CANADA
Institute for Safe Medication Practices Canada
Institut pour la sécurité des médicaments aux patients du Canada