Royal Victoria
Regional Health Centre

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STATEMENT TO DIAGNOSTIC, OPERATIVE, OBSTETRICAL OR THERAPEUTIC PROCEDURES

Please print – excluding signatures

1. I, ______________________________, hereby consent to the following procedure(s):
   (name of patient or consenting person)

   left / right cataract extraction + IOL implant
   (please circle one)

   ____

   to be performed upon myself
   (myself or name of patient)

   by Dr.(s) Azizi

2. The nature of the treatment, the expected benefits, the therapeutic alternatives, the material risks, the material side effects of the treatment, and the likely consequences of not having the treatment, have been explained to me by Dr. Azizi. I am satisfied with these explanations and I understand them.

3. I consent to all preliminary and related procedures and to the administration of general and/or other anaesthetics.

4. I also consent to such additional or alternative investigations, treatments or operative procedures as may be deemed necessary and/or medically advisable during the course of the above procedure(s).

5. I hereby agree that the above named doctor(s) may make use of the assistance of other surgeons, physicians, and hospital staff and may permit them to order or perform all or part of the diagnostic, operative, obstetrical, therapeutic or anaesthesia procedure(s). They shall have the same discretion in the performance of the procedure(s).

6. For scientific and educational purposes I also consent to the taking, publication and use of photography, motion pictures, video tapes and sound recordings in the course of this operation or procedure, and to the attendance of personnel in an educational capacity.

Dated this __________ day of ______________________________, 20____ Time ______________

____
(Signature of Patient or Consenting Person)

INSTRUCTIONS FOR COMPLETION ON REVERSE

RVH-0015
01/2010

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GUIDELINES FOR STATEMENT TO DIAGNOSTIC, OPERATIVE, OBSTETRICAL OR THERAPEUTIC PROCEDURES (RVH-0015)

1. Refer to Administration Policy and Procedure Manual, #1.040.

2. Who may sign the consent?
   Refer to Administration Policy and Procedure Manual, #1.040 – Appendix A.

   NOTE: If the consent is to be modified in any way, the modification should be so stated and signed by the patient above his/her signature.

3. The name of the procedure must be printed with no abbreviations or short forms and must specify site of the procedure e.g. right, left, bilateral, arm, leg, etc.

4. The O.R. Schedule is used as a guideline for the name of the investigation, treatment or operative procedure for ELECTIVE BOOKINGS. The history, admitting diagnosis etc. are also consulted. If any doubt remains, the physician is contacted. For add-on and emergency procedures, the name of the investigation, treatment or operative procedure is found in the DR's. ORDERS.

5. The initial and surname of the physician ordering or performing the procedure must be printed in the designated areas.

6. Following review of consent with the patient/responsible person, the individual witnessing the consent will ask the person consenting if he/she understands the consent, and will request his/her signature in the designated place. If the person consenting does not understand, the physician concerned must be notified.

7. A consent is valid from the date of admission until consented procedure has been performed.

8. A consent is not required where the surgeon believes that the delay caused by obtaining a consent would endanger the life or a limb or vital organ of the patient. The surgeon shall write and sign a statement to that effect.

9. Telephone Consents:
   Refer to Administration Policy and Procedure Manual, #1.040 – Telephone Consent section.

10. If a patient/substitute decision maker disagrees with any part of consent he/she can indicate by drawing a line through that portion, initialling and dating. Bring this change to the attention of the treating physician.

11. Interpreter Assistance used during explanation of procedure: Consent form must be signed by patient or as in number 2 above.

Royal Victoria Regional Health Centre

PREPARING FOR YOUR CATARACT SURGERY

Surgery date: ___________________

Arrival time: _____________________

On the day of your surgery, report directly to **Barrie Lasik Centre, 500 Huronia Road, Suite 204**

Three business days before surgery:
You will receive a call providing you with an arrival time for your surgery. Please ensure there is someone to receive this call or that your voice mail clearly states your name so we can leave a message.

Day of your Surgery: (Your surgery may be ***cancelled*** if you do not follow these instructions)

Do not eat anything after midnight including chewing gum or hard candy.
Do not drink dairy, dairy substitute, or orange juice
You may drink clear fluids (i.e., water, clear tea or black coffee with sugar, apple juice or sports drinks) up until **1 hour before your arrival time**.

The exception: Take all your usual morning medication(s) by 6:00 a.m. with a sip of water, unless otherwise instructed by your Surgeon. If you have any questions, contact your surgeon's office or your family doctor.

General Instructions:

- **If you are experiencing any cold/flu symptoms prior to your surgical date, please contact your surgeon's office for instructions.**
- **Do not drink alcoholic beverages (including wine and beer) for at least 12 hours before your surgery.**
- **CANNABIS (Marijuana):**
  - **Smoked/Vaporized/Ingested: STOP 12 hours before Surgery**
- **CANNABIDIOL (CBD OIL):**
  - **Oral Dosing/Ingested: STOP 4 hours before Surgery**
- **Do not use other recreational drugs such as cocaine, ecstasy etc. for 48 hours before your surgery.**
- After your surgical procedure you will not be permitted to drive yourself home or leave unaccompanied in a taxi. Arrangements must be made in advance to have someone accompany you home.
- You must make arrangements to have a responsible adult with you at home and remain with you **overnight** following surgery.
- Bring your **up to date health card** and any other health insurance information (i.e. Blue Cross) with you.

PREPARING FOR YOUR CATARACT SURGERY

General Instructions Continued:

- Complete any required paperwork if you have not already done so and bring it with you on the day of your surgery, including: **Anesthetic Questionnaire and Pre-Surgery Medication Review.**
- Please have a bath or shower at home either the evening before or the morning of your surgery unless advised otherwise.
- Do not wear makeup, perfume, scented products, or aftershave.
- Remove all jewelry including body piercings and leave valuables (purse, phone) at home, or with your driver
- Cataract patients are required to wear a **button-down** shirt. You will not be required to change into hospital attire.
- Remove your contact lenses and bring your glasses and glass case.
- **If you are a diabetic, please bring your Glucometer to your surgical appointment**

Surgical Safety Checklist:

RVH is dedicated to patient safety. On the day of your procedure, you will be asked to participate in the Surgical Safety Checklist with the members of the surgical team. This process will be carried out prior to your procedure and will occur again during and at the end of your procedure. This checklist is one of the many things we do at RVH to ensure your safety and comfort.

Special Instructions:

____
____
____

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ANESTHETIC QUESTIONNAIRE

NAME: ________________________________

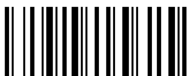
DOB: ___________________________

HRN: ___________________________

(addressograph)

IMPORTANT!
Fill this out before you see the anesthesiologist.
It helps the doctor giving your anesthetic (the anesthesiologist) to provide you with safe care.
Don't forget to bring it with you on the day of your procedure or pre-operative visit.

Anesthesia History:	**Yes**	**No**	**Explain**
1. Have you ever had any problems with an anesthetic?	❑	❑	____________
2. Has anyone related to you ever had problems with an anesthetic?	❑	❑	____________
3. Do you or any of your relatives have Malignant Hyperthermia or Pseudocholinesterase Deficiency?	❑	❑	____________
4. Have you ever developed confusion during a hospital admission?	❑	❑	____________
Social History: (Smoking, alcohol, and other recreational drugs can affect your anesthetic)			
5. Do you smoke cigarettes or have you ever smoked cigarettes?	❑	❑	____________
How many years have you or did you smoke for? ______________			
If you used to smoke, when did you quit? ______________			
6. Do you smoke or use marijuana? How often? ______________	❑	❑	____________
7. Do you drink alcohol or beer?	❑	❑	____________
How many drinks per day __________ per week ______________			
8. Do you use recreational drugs (e.g. cocaine, ecstasy, crystal meth)?	❑	❑	____________
Head and Neck:			
9. Do you have dentures, caps, bridgework, implants or loose teeth?	❑	❑	
10. Do you have any problems opening your mouth fully?	❑	❑	____________
11. Do you have problems with your neck? (e.g. arthritis, surgery, etc.)	❑	❑	____________
Cardiovascular System (heart, blood pressure):			
12. Can you walk two blocks or climb two flights of stairs without stopping?	❑	❑	____________
13. Do you take medication to thin your blood?	❑	❑	____________
14. Have you ever had a blood transfusion?	❑	❑	____________
15. Did you have any problems following your transfusion?	❑	❑	____________
16. Do you take antibiotics prior to dental work or surgery?	❑	❑	____________
17. Do you or any of your relatives have sickle cell disease or trait?	❑	❑	____________
Have you had or do you have:			
18. High Blood Pressure	❑	❑	____________
19. Heart Attack or angina	❑	❑	____________
20. Stents or cardiac bypass surgery	❑	❑	____________
21. Heart failure or heart rhythm abnormalities	❑	❑	
22. Do you have a pacemaker or Implantable Defibrillator (ICD)?	❑	❑	____________
23. Heart Valve Problems or Valve Replacement or "murmur"	❑	❑	____________
24. Stroke or Mini Stroke (TIA)	❑	❑	____________
25. Peripheral Vascular Disease/problems with circulation	❑	❑	____________
26. Blood Clots (Phlebitis) or pulmonary embolism	❑	❑	____________



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ANESTHETIC QUESTIONNAIRE

NAME: ____________________

DOB: ____________________

HRN: ____________________

Respiratory System (lungs and breathing)	Yes	No	Explain
27. Do you ever have difficulty breathing even when resting or sitting?	❑	❑	______
28. Does shortness of breath ever wake you up at night?	❑	❑	______
29. Have you ever used puffers or home oxygen for your breathing?	❑	❑	______
Have you had or do you have?			
30. Asthma/chronic bronchitis/emphysema/wheezing/chronic cough	❑	❑	______
31. Recent respiratory infection, cough or common cold	❑	❑	______
32. Sleep apnea, severe snoring or breath holding at night	❑	❑	______
Other Systems: Have you had or do you have?			
33. Diabetes Type 1 or 2	❑	❑	______
34. Thyroid Problems	❑	❑	______
35. Hiatus Hernia/reflux or frequent acid indigestion	❑	❑	______
36. Crohn's disease or Ulcerative Colitis	❑	❑	______
37. Rectal bleeding or stomach ulcers	❑	❑	______
38. Hepatitis, HIV or Tuberculosis	❑	❑	______
39. Cirrhosis or jaundice	❑	❑	______
40. Kidney problems or hemo/peritoneal dialysis	❑	❑	______
41. Epilepsy or Seizures	❑	❑	______
42. Arthritis	❑	❑	______
43. Neurological or muscular disease	❑	❑	______
44. Glaucoma or Eye Problems	❑	❑	______
45. Chronic pain or fibromyalgia	❑	❑	______
46. Any cortisone injections or taken any cortisone-like medication (e.g. Prednisone) in the last year	❑	❑	______
47. Cancer Please specify where: ______	❑	❑	______
48. Anemia/low blood count	❑	❑	______
49. Is there a chance you may be pregnant?	❑	❑	______

Please list any other medical problems not mentioned above. ____________________

____

Please list previous surgeries and hospital admissions or visits below.

Year	Surgery or Hospital Admission	Year	Surgery or Hospital Admission

Do you have any questions about your anesthetic? ____________________

R.AQ

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PRE-SURGERY MEDICATION REVIEW

PATIENT NAME: ______________________________

DOB: ____________________

HRN: ____________________

(addressograph)

TO THE PATIENT: Please complete as much of the information below as possible

Community Pharmacy(s): ____________________________________ Tel. # ______________________________

____________________________________ Tel. # ______________________________

Height: __________ cm __________ inches Weight: ____________ kg ____________ lbs

ALLERGIES

(eg. hives, rash, swelling, difficulties breathing)

Agent (eg. drugs, foods)	Type of reaction?	Age at occurrence

INTOLERANCES

(eg. nausea, upset stomach, dizziness, hallucinations)

Agent (eg. drugs, foods)	Comments

Pre-Surgery:
Nurse Employee #: _______________ Nurse Signature: ____________________________ Date: _______________

Surgery-Preparation:
Nurse Employee #: _______________ Nurse Signature: ____________________________ Date: _______________

R.PSMR

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PRE-SURGERY MEDICATION REVIEW

PATIENT NAME: ______________________________

DOB: ____________________

HRN: ____________________

MEDICATIONS TAKEN BY PATIENT

*(please fill out as completely as possible **- NOT SHADED AREAS)***

Pt. to Bring Own (✓)	Pt. to ask about holding preop (✓)	Name of Drug	Dose	Directions	Date/Time Last Dose Taken

NON-PRESCRIPTION MEDICATIONS

(eg. herbals, OTC, vitamins & minerals, recreational)

Pt. to ask about holding preop (✓)	Name of Drug	Dose	Directions	Date/Time Last Dose Taken

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DEPARTMENT OF ANESTHESIA

CANNABIS BEFORE SURGERY

Information About Cannabis Use Prior to Your Operation

What if I am using cannabis for medical purposes?

It is routine for patients to be asked to discontinue prescribed medications before surgery. Cannabis is no different.

Is smoking cannabis safer than smoking cigarettes?

No. You are at risk of developing lung disease from smoking cannabis. Lung disease from either cannabis or cigarette smoking may increase Anesthesia related complications, and could affect healing after surgery.

Does Cannabis Use Increase My Anesthetic Risk?

This is a difficult question to answer. Anesthetic risk has many variables and is often related to your unique medical issues and specific surgery. Individuals who use cannabis do so in many ways, forms and amounts. Therefore, its effect on the body is difficult to predict when combined with a wide variety of anesthetic agents and techniques.

Currently, we do not have enough evidence to say that cannabis ***alone*** will increase your anesthetic risk **when stopped at an appropriate time.** Although it is recommended that you abstain from cannabis use ***as long as possible*** prior to your surgery, below is the minimum time you would be expected to stop before receiving an anesthetic.

CANNABIS (MARIJUANA)
Smoked/Vaporized: STOP 12 hours before Surgery
Ingested: STOP 12 hours before Surgery

CANNABIDIOL (CBD OIL)
Oral Dosing/Ingested: STOP 4 hours before Surgery

Your attending Anesthesiologist has a legal obligation to provide you with the safest care possible during your surgery. On rare occasions there may be times where your surgery is delayed, postponed or canceled at their discretion.

Under **no** circumstances will you receive an anesthetic for nonemergency surgery if you are intoxicated.

201 Georgian Drive | Barrie ON | L4M 6M2 | 705.728.9802
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