GUELPH
GENERAL HOSPITAL

OUTPATIENT SERVICES
DAYCARE RECORD

DR IAN PHILLIPS
general surgeon

DATE: _____ PROCEDURE: _____ SURGEON: _____

MUST HAVE RIDE HOME: Yes ☐ Name _____ Phone Number _____

PATIENT INFORMATION
(Please complete and check boxes that are applicable)

Height _____ Weight _____

ALLERGIES
(List drug, food, contrast and environmental allergy and reaction)

DRUG ALLERGIES: _____

CONTRAST: _____

FOODS: _____

ENVIRONMENTAL: _____

Have you had a reaction to: general anaesthetic No ☐ Yes ☐
local anaesthetic No ☐ Yes ☐

Do you have Malignant Hyperthermia? No ☐ Yes ☐

Do you wear dentures No ☐ Yes ☐ bridges No ☐ Yes ☐
dental caps/crowns No ☐ Yes ☐ loose teeth No ☐ Yes ☐

Do you have any body piercing/jewelry? No ☐ Yes ☐
(Piercings must be removed prior to registering for surgery)

Have you ever been treated for lung disease? No ☐ Yes ☐
Sleep Apnea No ☐ Yes ☐ Smoker No ☐ Yes ☐

Have you ever been treated for:
Diabetes No ☐ Yes ☐ Glaucoma No ☐ Yes ☐
Hepatitis No ☐ Yes ☐ HIV No ☐ Yes ☐

If yes, specify when _____

Do you have any metal in your body from surgery? No ☐ Yes ☐
Specify Location _____

Have you ever been treated for any heart disease? No ☐ Yes ☐
high blood pressure No ☐ Yes ☐ or stroke? No ☐ Yes ☐

Do you have a blood disorder? No ☐ Yes ☐
Are you on blood thinners? _____ No ☐ Yes ☐

CURRENT MEDICATION(S) NAME ☐ see med profile	DOSAGE	FREQ	LAST DOSE TAKEN

	DATE	TIME (hh:mm)
Ate last		
Drank last		

Bowel Prep taken as ordered? No ☐ Yes ☐
Results: Clear ☐ Yellow ☐ Brown ☐ Solid ☐

Nurses Section Only

Temp _____ B.P. _____
Pulse _____ SPO2 _____
Resp _____ CBGM _____

Completed by: _____ If not, patient state relationship _____
(Please print)

Date: _____ Signature _____

Signature of Nurse Sending _____ Signature of Nurse Receiving _____