**PAIN CLINIC CHECKLIST**

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| **Chart Review** |
| **Pre-Signed Consent Needed** | **Yes** | **No** |
|  *(Unable to sign / POA / Advanced Directives)*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Nursing Info**  |
| **Driver: Ph #** |
| **Weight: \_\_\_\_\_lbs \_\_\_\_\_kg Height: \_\_\_\_\_\_ft \_\_\_\_\_in** |
| **B/P:** | **O2:** |
| **T:** |  | **P:** |  | **R:** |  |

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| **Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Latex Allergy?** | **Yes** | **No** | ***Comments*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Betadine Allergy?** | **Yes** | **No** | ***Comments*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **IVP Dye?** | **Yes** | **No** | ***Comments*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **PT Appt?** | **Yes** | **No** |
| **Chiropractor Appt?** | **Yes** | **No** |
| **Last Steroid Injection:** |

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| **Labs / Scans** |
| **HCGU:** | **If no tubal/hyst/period > 1 yr.** |
| **PT/INR:** |
| **BGM:** |
| **Other:** |
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| **Illness / Infections  *(Circle If applicable)*** |
| * **Recent Illness**
* **Recent Infections**
* **Recent Lyme’s**
* **Open Cuts/Sores**
* **None**
 |
| *Comments:* |

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| **Medications** |
| **Meds Today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Last Dose of ASA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Last Dose of Plavix / Coumadin Warfarin / Other:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Pre-Op Rm #** | **CRNA:** |
| **Procedure Date:** | **Arrival Time:** |