**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:** |