This convenient step-by-step guide will help you to prepare for your surgery at Seton Medical Center Austin. Please bring this guide with you for all appointments relating to your surgery.
We know that having surgery can be stressful for the patient as well as the patient's family. This guide can help reduce the stress.

Our staff is committed to providing the best of care and providing the information you and your family need to feel truly connected to your healthcare team.

We are committed to an excellent patient experience. If for any reason you and your family members are not having a positive experience, please tell us. We welcome information from your point of view. All departments have managers willing to listen and help.

Seton Medical Center Austin also has a patient representative available to address your concerns or compliments relating to your hospital experience. Please do not hesitate to contact our patient representative, at 512-324-1122.
Questions for Your Healthcare Provider or Nurse

Please bring this with you to all of your appointments relating to your surgery/procedure, including the day of the surgery/procedure.

If you are interested in keeping family or friends informed of your status while here at Seton Austin, please register to use the online site Caring Bridge before you arrive. This site helps you to share information and coordinate support during your health event, as well as receive get well messages! Log on to CaringBridge.org, click on “Start a Site” and follow the directions. You can then invite family and friends to your site.

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If you have questions after reviewing this information, please call the Seton Medical Center Austin Surgery Department at 512-324-3264, Monday through Friday between 8 a.m. – 5 p.m.
Mission

Our mission inspires us to care for and improve the health of those we serve with a special concern for the poor and vulnerable. We are called to be a sign of God's unconditional love for all and believe that all persons by their creation are endowed with dignity. Seton continues the Catholic tradition of service established by our founders: Vincent de Paul, Louise de Marillac and Elizabeth Ann Seton.

Vision

Guided by the needs of those we care for and their families, Seton is a person-centric comprehensive delivery system that seeks to meet the health care needs of one million Central Texans while reducing inappropriate use of acute care.

Seton is an effective advocate for a socially just and fully accessible health care delivery system in Central Texas.

Seton is a community that models the values and aspirations of Ascension Health and the Daughters of Charity of St. Vincent de Paul.

Getting to Seton Medical Center Austin

From IH-35
• IH-35 to 38 1/2 St. exit
• 38th St. west to Medical Parkway (one block west of Lamar Blvd.)
• Medical Parkway south one-half block to Emergency/South Entrance
• Parking available in the South Parking Garage
• Limited valet parking available at the north entrance

From Mopac (Hwy 1 Loop)
• Mopac to 35th St. exit
• 35th St. east (it becomes 38th St. at Jefferson) to Medical Parkway (you will drive past SMC Austin)
• Medical Parkway south one-half block to Emergency/South Entrance
• Parking available in the South Parking Garage
• Limited valet parking available at the north entrance

Where to Park

On the day of your scheduled pre-admission testing and on the day of your scheduled surgery/procedure, you are allowed free parking for one car in either the valet parking area or the South Parking Garage. Valet parking is located at the North entrance on 38th Street. If the valet parking area is full, proceed to the South Parking Garage located at the Emergency/South Entrance. Handicap parking is located immediately outside the Emergency Entrance. If you exit either parking area, you will be expected to pay to re-enter. The fee for valet parking is $10. Parking is charged hourly in the South Parking Garage, with a maximum daily charge of $9. All parking costs listed are subject to change.

Helpful Hint

Surgery Check-In is at the North entrance on the first floor. If you park in the garage at the South entrance, you will enter the hospital on the ground floor and need to take the elevator to the first floor and proceed north (follow signage to Surgery).

Endoscopy Procedure Check-In is located at the Admission desk on the ground floor of the South Lobby. Please park in the South Garage. Once you have entered the South entrance you will see the Admissions desk immediately to your left.
Registration Process

Our goal is to provide excellent care starting at the point of registration. We are committed to making your experience positive, friendly and efficient. With that goal in mind, a representative from Registration will contact you prior to your scheduled surgery or procedure. As part of the process, our staff will contact your insurance carrier to determine your benefits eligibility.

The representative will ask for your insurance information, update your personal demographics and inform you of your financial obligation to the hospital.

On the day of your registration, you will need to bring the following items:

- Social Security Number
- Medical Insurance card(s)
- Copy of current Advance Directive/Living Will
- All consent forms, papers from your doctor's office
- Photo ID (driver's license or other state-issued ID, or military ID)
- Method of payment (check, cash, credit or debit card)

Upon arriving at the hospital for pre-admission, please sign in at the registration desk. Our registration representatives will verify that all your information is correct, have you sign all necessary forms and collect any financial obligation. If you have any other questions regarding your registration you can contact us at 512-324-8750.

For your safety, you should expect to be asked to verify your name, date of birth and surgical or procedural site multiple times throughout your services here at Seton Austin to ensure accuracy.

If you have questions regarding the Advance Directives, please be sure to ask the patient representative during your pre-registration.

Patient Rights and Responsibilities

In keeping with the SETON Healthcare Family's mission, philosophy, core values and commitment to the delivery of quality health care, SETON recognizes, protects and promotes the following rights for each patient, or when appropriate his/her legally authorized representative (referred to in this document as "the patient").

As a Seton patient, you have the right to:

- Participate in the development, implementation, and decision-making regarding your plan of care, including pain management.
- Make informed decisions regarding your care, including being informed of your health status, being involved in your care planning and treatment.
- Request or refuse treatment.
- Complete advance directives and have Seton staff and practitioners comply with these directives in accordance with the law and Seton policy.
- Have a family member or representative of your choice and your physician notified promptly of your admission to the hospital.
- Have a guardian, next of kin, or legally authorized responsible person to exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient has been adjudicated incompetent in accordance with the law; is found by his/her physician to be medically incapable of understanding the proposed treatment or procedure; is unable to communicate his/her wishes regarding treatment; or is a minor.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Confidentiality of your clinical records in accordance with law.
- Access information contained in your clinical record within a reasonable time frame.
- Be free from seclusion and restraints of any form that are not medically necessary including restraints used as a means of coercion, discipline, convenience or retaliation by staff for acute medical care, surgical care or behavioral management.
- Receive reasonable access to care.
- Care that is considerate and respectful of personal values and beliefs.
- Participate in ethical issues that may arise in the course of your care.
- Receive information about clinical research or educational projects affecting your care or treatment including the expected benefits, potential discomforts, risks and alternatives.
- Receive a reasonable response to requests for treatment or service.
- Appropriate assessment and management of pain.
- Have Seton use its best efforts to meet your special communication needs.
- Receive upon request Seton's policies related to patient rights.
- Be informed of Seton's complaint/grievance process and to voice complaints or concerns without affecting your care or treatment.
- Accept or refuse medical care to the extent permitted by law, or to change your mind regarding your care.
- Be informed of Seton's rules and regulations that apply to patient care and conduct.
- Request and receive a detailed explanation of your bill.
- Choose, unless restricted for clinical or safety reasons by medical staff or Seton administration, who may visit during the in-patient stay, regardless of whether the visitor is a spouse, a domestic partner (including a same-sex domestic partner), a family member, or a friend. Seton patients also have the right to withdraw or deny this consent to visitation at any time. Seton respects the visitation rights of those we serve regardless of age, race, ethnicity, color, national origin, religion, culture, language, physical or intellectual disability, socioeconomic status, sexual orientation, or gender identity or expression. Seton ensures that all visitors enjoy full and equal visitation privileges in accord with patient preferences.
Seton Financial Policy

Seton Medical Center Austin is committed to quality in all aspects of patient care. We realize that financial issues may be difficult to discuss, especially during times of illness and other stress-related hospital visits. We will assist you with respect, honesty and simplicity so that our mutual responsibilities can be met. We establish your account upon notification of your admission. We will contact you prior to the admission, if possible, to obtain necessary information and determine your amount of insurance coverage, along with your remaining expected financial responsibility.

A deposit toward co-payments, deductibles and items not covered by insurance is requested at the time of pre-registration, pre-admission testing or admission the day of the procedure. Seton will accept cash, check, money orders and major credit cards. For patient convenience, Seton has an online payment website (seton.net/billpay) that allows you to remit balances due with an approved credit card prior to service. Our staff members are available to assist with options for meeting your financial responsibility.

Other Charges

Certain physician specialists may bill you directly for the professional component of certain services. Typically, radiology, anesthesia and pathology services in the hospital will result in such professional billings. Their billing is separate from your hospital bill, and is not a duplication of billing. If you should receive a bill from a specialty clinic, and you have questions regarding that bill, you would need to contact that professional component directly.

Information Concerning Tobacco and Electronic Devices

The Seton Healthcare Family is committed to ensuring the health, safety and welfare of all individuals using our facilities and services. Consistent with our values as a health care institution, tobacco and electronic devices like e-cigarettes are prohibited for all staff, patients and visitors at Seton facilities.

Our smoke-free Policy went into effect November 2007, and expanded in September 2014 to ban electronic devices. This means smoking, tobacco products and electronic devices are not permitted anywhere inside our facilities. They are also prohibited on Seton grounds, including entranceways and all parking garage areas. This policy is in effect at Seton's leased facilities where patient care is provided.

While we are not asking people to quit smoking, it is our hope that a smoke-free environment will provide the opportunity to do so. Please talk with your physician or a nurse about smoking cessation support information and resources available to assist you during your visit to our facility.

Thank you for your cooperation with the Seton Healthcare Family smoke and device free Policy. Your efforts help maintain a healthier environment for everyone.

Preparing for Your Surgery

What to Expect During Pre-admission Testing

A staff member will call you to schedule a pre-admission testing appointment prior to the day of surgery. During this appointment, your medical history will be reviewed. If required, you may have lab work, and you may speak with an anesthesiologist. You may contact the pre-admission nurse at 512-324-1163 for additional information.

What to Bring for Your Pre-admission Testing Visit:

- This guidebook with questions for the anesthesiologist/nurse
- List of allergies including medications, food, latex, rubber or dyes
- List of medications including over-the-counter and vitamin supplements (how often and how much taken).
  A list has been provided in the forms section for you to write down your medication information.

The Day Before Surgery/Procedure

For your safety, do not eat or drink anything after midnight unless instructed otherwise by the anesthesia staff. We recommend that you do not smoke 24 – 48 hours before your surgery to enhance your breathing.

The Day Of Your Surgery/Procedure

Do Not:

- wear eye make-up or jewelry, including body piercings.
- bring valuables, including prescription medications.
- wear contact lenses.
- clip or shave the surgical area.

Do:

- take a bath or shower to reduce the chance of infection.
- wear clothing that is easy to take off and put on.
- contact your doctor or surgeon if you are sick or have a skin rash.
- bring appropriate cases for eyeglasses, hearing aids, dentures.

You must have a responsible adult present to take you home or your surgery cannot proceed.

Anesthesia

If you have not already met with the anesthesiologist, he/she will visit with you on the day of your surgery. He/she will review your planned procedure, medical history and laboratory studies. Your post operative pain management may also be discussed.
After Your Surgery/Procedure

After your surgery, you may be taken to the Post Anesthesia Care Unit (PACU), also known as the recovery room. The nursing staff will attend to your immediate recovery from surgery and the anesthesia. Your stay in the PACU may last 1½ to 2 hours on average or until your vital signs are stable. If you will be discharged after your surgery/procedure (same day surgery), you must have a responsible adult drive you home.

A registered nurse will call you a day or two after your surgery to check your progress.

If you are being admitted, your family will be notified of your room assignment. Whether you are admitted or discharged, we highly recommend a responsible adult stay with you for the first 24 hours after your surgery/procedure.

Additional Information:

- If you have been given a specific time to arrive, please do so to avoid any possible delays. The hospital will confirm your arrival time during your pre-admission visit.

- Remember to bring this guidebook, along with your questions; a copy of your Advance Directives; Power of Attorney or Directive to Physicians or Family and Surrogates (both in the back of this guide) or a donor card; and a list of medications.

Obstructive Sleep Apnea (OSA)

Please let us know if you have been diagnosed with OSA. For your safety, if you have been diagnosed with sleep apnea, please bring your own CPAP/BIPAP or breathing machine, all tubing, masks and other items associated with that machine.

Pain Management After Surgery

It is normal to experience some pain after any surgery/procedure. Seton Medical Center Austin uses a pain scale of 0 – 10 to help patients describe their pain level. Your pain level is unique to you.

Pain Scale

The pain scale is a tool to provide quick, consistent communication between you and your caregiver. It also gives us measurable information and allows us to set realistic goals.

Using the pain scale helps your care team know how well the comfort measures being used to manage your pain are working. Our goal is to make you as comfortable as possible during and after your surgery/procedure.

0 - No Pain 2 - Tolerable 4 - Moderate 6 - Worst Pain

Remember there is no right or wrong answer. This is simply your judgement of pain.

CALL, DON’T FALL

We care about your SAFETY! ALWAYS ask for help, even if you don’t think you need it!

FAQs About “Surgical Site Infections”

What is a Surgical Site Infection (SSI)?

A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place. Most patients who have surgery do not develop an infection. However, infections develop in about one to three out of every 100 patients who have surgery. Some of the common symptoms of a surgical site infection are redness and pain around the area where you had surgery, drainage of cloudy fluid from your surgical wound or fever.

Can SSIs be treated?

Most surgical site infections can be treated with antibiotics. The antibiotic given to you depends on the bacteria (germs) causing the infection. Sometimes patients with SSIs also need another surgery to treat the infection.

What are some of the things that hospitals are doing to prevent SSIs?

To prevent SSIs, doctors, nurses and other healthcare providers:

- Clean hands and arms up to their elbows with an antiseptic agent just before the surgery.
- Clean hands with soap and water or an alcohol-based hand rub before and after caring for each patient.
- May remove some of your hair immediately before your surgery using electric clippers if the hair is in the same area where the procedure will occur. They should not shave you with a razor.
- Wear special hair covers, masks, gowns and gloves during surgery to keep the surgery area clean.
- Give you antibiotics before your surgery starts. In most cases, you should get antibiotics within 60 minutes before the surgery starts and the antibiotics should be stopped within 24 hours after surgery.
- Clean the skin at the site of your surgery with a special soap that kills germs.

What can I do to help prevent SSIs?

Before your surgery:

- Tell your doctor about other medical problems you may have. Health problems such as allergies, diabetes and obesity could affect your surgery and your treatment.
- Quit smoking. Patients who smoke get more infections. Talk to your doctor about how you can quit before your surgery.
- Do not shave near where you will have surgery. Shaving with a razor can irritate your skin and make it easier to develop an infection.

At the time of your surgery:

- Speak up if someone tries to shave you with a razor before surgery. Ask why you need to be shaved and talk with your surgeon if you have any concerns.
- Ask if you will get antibiotics before surgery.

After your surgery:

Make sure that your healthcare providers clean their hands before examining you, either with soap and water or an alcohol-based hand rub.

If you do not see your providers clean their hands, please ask them to do so.

- Family and friends who visit you should not touch the surgical wound or dressings.
- Family and friends should clean their hands with soap and water or an alcohol-based hand rub before and after visiting you. If you do not see them clean their hands, ask them to clean their hands.

What do I need to do when I go home from the hospital?

- Before you go home, your doctor or nurse should explain everything you need to know about taking care of your wound. Make sure you understand how to care for your wound before you leave the hospital.
- Always clean your hands before and after caring for your wound.
- Before you go home, make sure you know who to contact for questions or problems after you get home.
- If you have any symptoms of an infection, such as redness and pain at the surgery site, drainage or fever, call your doctor immediately.

If you have additional questions, please ask your doctor or nurse.
Five Things You Can Do to Prevent Infection

Avoiding contagious diseases like the common cold, strep throat and the flu is important to everyone. Here are five easy things you can do to fight the spread of infection.

1. Clean your hands.
   • Use soap and warm water. Rub your hands really well for at least 15 seconds. Rub your palms, fingernails, in between your fingers and the backs of your hands.
   • Or, if your hands do not look dirty, clean them with alcohol-based hand sanitizers. Rub the sanitizer all over your hands, especially under your nails and between your fingers, until your hands are dry.
   • Clean your hands before touching or eating food. Clean them after you use the bathroom, take out the trash, change a diaper, visit someone who is ill or play with a pet.

2. Make sure health care providers clean their hands or wear gloves.
   • Doctors, nurses, dentists and other health care providers come into contact with lots of bacteria and viruses. So before they treat you, ask them if they’ve cleaned their hands.
   • Health care providers should wear clean gloves when they perform tasks such as taking throat cultures, pulling teeth, taking blood, touching wounds or body fluids, and examining your mouth or private parts. Don’t be afraid to ask them if they should wear gloves.

3. Cover your mouth and nose.
   Many diseases are spread through sneezes and coughs. When you sneeze or cough, the germs can travel three feet or more! Cover your mouth and nose to prevent the spread of infection to others.
   • Use a tissue! Keep tissues handy at home, at work and in your pocket. Be sure to throw away used tissues and clean your hands after coughing or sneezing.
   • If you don’t have a tissue, cover your mouth and nose with the bend of your elbow or hands. If you use your hands, clean them right away.

4. If you are sick, avoid close contact with others.
   • If you are sick, stay away from other people or stay home. Don’t shake hands or touch others.
   • When you go for medical treatment, call ahead and ask if there’s anything you can do to avoid infecting people in the waiting room.

5. Get shots to avoid disease and fight the spread of infection.
   Make sure that your vaccinations are current — even for adults. Check with your doctor about shots you may need. Vaccinations are available to prevent these diseases:
   • Chicken pox
   • Mumps
   • Measles
   • Diphtheria
   • Tetanus
   • Hepatitis
   • Shingles
   • Meningitis
   • Flu (also known as influenza)
   • Whooping cough (also known as Pertussis)
   • German measles (also known as Rubella)
   • Pneumonia (Streptococcus pneumoniae)
   • Human papillomavirus (HPV)

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FORMS

This section contains important forms and documents. Please tear out the forms and bring them with you to your surgery or procedure.
### Universal Medication Form

**Name and Phone Number of Preferred Pharmacy:**

---

**IMMUNIZATION RECORD**

(Record the date/year of last dose taken, if known)

- [ ] TETANUS
- [ ] FLU VACCINE(S)
- [ ] PNEUMONIA VACCINE
- [ ] HEPATITIS VACCINE
- [ ] OTHER

---

**No Known Drug Allergies**  [ ] Height: __________ Weight: __________ lb / kg (Circle one)

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<table>
<thead>
<tr>
<th>Drug Allergy</th>
<th>Reaction</th>
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<tbody>
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<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Last Dose Taken</th>
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<tbody>
<tr>
<td>Prescription and non-prescription drugs, vitamins, herbal supplements, etc.</td>
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</table>

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This worksheet is not part of the patient’s permanent chart.

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Continued on back
Write down all of the medicines you are taking and list all of your allergies.

WRITE DOWN ALL CHANGES MADE TO YOUR MEDICINES on this form. If you stop taking a certain medicine, draw a line through it and write the date it was stopped. If help is needed, ask your doctor, nurse, pharmacist or family member to help you to keep it up to date.

When you are discharged from the hospital, someone will talk with you about WHICH MEDICINES TO TAKE AND WHICH MEDICINES TO STOP TAKING. Since many changes are often made after a hospital stay, a new form should be filled out. When you return to your doctor, take your new form with you. This will keep everyone up to date on your medicines.

HOW DOES THIS FORM HELP YOU?

This form helps you and your family members remember all of the medications you are taking.

This form provides your doctor(s) and others with a current list of ALL of your medications. Doctors need to know the herbals, vitamins and over-the-counter medicines you take!

Concerns may be found and prevented by knowing what medicines you are taking.

**Medication Name**
- Prescription and non-prescription drugs, vitamins, herbal supplements, etc.

**Strength**
- List the strength of the drug.

**Dose**
- How many do you take?

**Route**
- By mouth, injection, etc.

**Frequency**
- How often do you take this medication?

**Last Dose Taken**
- List the last date and time you took this medicine.

### Patient History Intake Form

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it ok to leave a message for you on your phone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who is completing this form?</td>
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<tr>
<td>Who will bring you to the hospital?</td>
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<tr>
<td>Who is your emergency contact?</td>
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<tr>
<td>Name and phone number:</td>
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</tr>
<tr>
<td>Please list the name and phone number of the person who will take you home when you are discharged:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will this person help to care for you when you get home?</td>
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</tr>
<tr>
<td>If no, list name and phone number of who will help care for you.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you pregnant?</td>
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<tr>
<td>Possible unconfirmed</td>
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<td></td>
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<tr>
<td>Negative confirmed</td>
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<tr>
<td>Positive confirmed</td>
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<tr>
<td>Due date</td>
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<tr>
<td>Hysterectomy</td>
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<tr>
<td>Not started menstruation</td>
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<td></td>
</tr>
<tr>
<td>First day of your last menstrual period</td>
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<td></td>
</tr>
<tr>
<td>Are you currently breastfeeding?</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. For females of childbearing age (12-55) N/A

- Are you pregnant?
  - Possible unconfirmed
  - Negative confirmed
  - Positive confirmed
  - Due date
  - Hysterectomy
  - Not started menstruation
  - First day of your last menstrual period
  - Are you currently breastfeeding?

7. **How tall are you?**

8. Please list any health problems you have or have had in the past. Please explain any “Yes” responses.

- Heart
- Lung
- Eye/Ears/Nose/Throat
- Have you been told you snore loudly?
- Is your neck larger than 17 inches?
- Do you often feel tired and sleepy during the day?
- Diabetes
- Thyroid/Endocrine disease
- Liver problems/Hepatitis
- Frequent heartburn
- Intestine/Stomach
- Kidney/Bladder/Incontinence
- Anemia
- Bleeding/Clotting Disorder
- Autoimmune disease (rheumatoid arthritis, sarcoidosis, lupus, etc.)
- Infections (HIV, Lyme disease, MRSA, TB, etc.) Please List:

These are screening questions for Sleep Apnea, also called “Obstructive Sleep Apnea” or “OSA.”
Health problems (continued) Please explain any “Yes” responses.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Skin</td>
<td></td>
</tr>
<tr>
<td>❑ Bone/Joint/Muscle (arthritis, osteoporosis, back pain, fibromyalgia )</td>
<td></td>
</tr>
<tr>
<td>❑ Neurological (ADD, MS, MD, CP, Alzheimer’s, Parkinson’s), migraines, numbness, etc. )</td>
<td></td>
</tr>
<tr>
<td>❑ Cancer</td>
<td></td>
</tr>
<tr>
<td>❑ Psychiatric (depression, anxiety, bipolar, PTSD, schizophrenia)</td>
<td></td>
</tr>
<tr>
<td>❑ Have you ever been told you are allergic to latex (balloons, gloves, condoms- not adhesives) or reacted to latex products? If yes, list your allergic symptoms:</td>
<td></td>
</tr>
<tr>
<td>❑ Have you had anesthesia/sedation in the past?</td>
<td></td>
</tr>
</tbody>
</table>

9. Please list all surgeries/procedures and dates

10. Please list any family medical history (blood relative) that we need to be aware of to provide your care during this admission.

11. Have you or any blood relative had any of the following reactions to anesthesia?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ High temperature caused by anesthesia</td>
<td></td>
</tr>
<tr>
<td>❑ Slow to regain muscle movement (Pseudocholinesterase Deficiency)</td>
<td></td>
</tr>
<tr>
<td>❑ Severe nausea &amp; vomiting after anesthesia</td>
<td></td>
</tr>
<tr>
<td>❑ Told it was difficult to place the breathing tube in your airway</td>
<td></td>
</tr>
<tr>
<td>❑ Prolonged confusion after anesthesia</td>
<td></td>
</tr>
<tr>
<td>❑ Significant change in blood pressure</td>
<td></td>
</tr>
<tr>
<td>❑ Motion sickness</td>
<td></td>
</tr>
</tbody>
</table>

12. Do you or have you ever used any of the following?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Tobacco products</td>
<td></td>
</tr>
<tr>
<td>❑ Alcohol</td>
<td></td>
</tr>
<tr>
<td>❑ Alternative medical treatments (acupuncture, herbal therapy, etc.)</td>
<td></td>
</tr>
<tr>
<td>❑ Recreational drugs</td>
<td></td>
</tr>
</tbody>
</table>

13. What is the patient/caregiver’s preferred language?

14. List any other language you are comfortable speaking:

15. Do you need an interpreter?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

16. Please check all that you presently have/ use:

<table>
<thead>
<tr>
<th>Glasses</th>
<th>Contacts</th>
<th>BIPAP/ CPAP</th>
<th>Removable Dental Pieces (Dentures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walker/Cane/Crutches/Wheelchair</td>
<td>Removable prosthesis</td>
<td>Oxygen at home</td>
<td></td>
</tr>
<tr>
<td>Hearing Aid Rights/Left/Both</td>
<td>Pacemaker and/or Defibrillator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. Do you have any dietary restrictions?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

18. Do you have any cultural, ethnic or religious beliefs that need to be included in your care or education while in the hospital?

<table>
<thead>
<tr>
<th>Yes (describe)</th>
<th>No</th>
</tr>
</thead>
</table>

19. While in the hospital, how will you learn best about your surgery/procedure?

<table>
<thead>
<tr>
<th>Doing</th>
<th>Reading</th>
<th>Hearing</th>
<th>Watching</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Caretaker/family</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. Do you or your caretakers have any barriers to learning?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing</td>
<td>Language</td>
</tr>
</tbody>
</table>

21. Have you enacted any of the following?

| Yes | No |
| Directive to Physicians |
| Medical Power of Attorney | If Yes, MPOA name, Phone number |
| Declaration for Mental Health Treatment | |
| Organ/Tissue Donation | |

22. Screening: Do you have:

| Yes | No |
| Night sweats |
| Bloody, persistent cough |
| Fever / chills |
Advance Directives and Resuscitation

Any request for Do-Not-Resuscitate (DNR) status requires special consideration when the patient will receive anesthesia or sedating medications as part of operative or other procedures. Because any anesthetic or sedating medications may compromise circulation or respiration, physicians and anesthetists may feel obliged to treat any compromise, which is due to the anesthetic or sedating medication. Resuscitative measures, when necessary, are considered a part of routine care during anesthesia or sedation.

When scheduled for surgery or other procedure requiring any form of anesthesia or sedating medication, the patient, family or designated surrogate, and those treating the patient must understand that routine anesthesia care or sedation care may include resuscitation (endotracheal intubation, ventilation or use of drugs to support circulation), regardless of the patient’s DNR status.

If resuscitation during a procedure poses a conflict with the patient’s DNR status or advance directive(s), the patient, family or designated surrogate should request to speak with the patient’s physician regarding the conflict.

DIRECTIVE

I, ____________________________________________(insert your name), recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld, and my physician allow me to die as gently as possible; OR
_____ I request that I be kept alive in this terminal condition using available life-sustaining treatment.

(THIS SECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld, and my physician allow me to die as gently as possible; OR
_____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment.

(THIS SECTION DOES NOT APPLY TO HOSPICE CARE.)

Instruction to Physicians and Family or Surrogates

INSTRUCTIONS FOR COMPLETING THIS DOCUMENT:

This is an important legal document known as an advance directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes usually are based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other healthcare provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative or other advisers. You also may wish to complete a directive related to the donation of organs and tissues.
Additional requests: (After discussion with your physician, you may wish to consider listing particular treatment in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values:

1. ___________________________________________________

2. ___________________________________________________

If the above people are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas. If, in the judgement of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed: _______________________________ Date: __________________

City, County, State of Residence: _______________________________________________________

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness 1 may not be a person designated to make a treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a healthcare facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1: _______________________________ Witness 2: _______________________________

DEFINITIONS:

• "Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

• "Irreversible condition" means a condition, injury or illness:
  1. that may be treated, but is never cured or eliminated;
  2. that leaves a person unable to care for or make decisions for the person’s own self; and
  3. that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver or lung), and serious brain disease, such as Alzheimer’s dementia, may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important people in your life.

• "Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient’s pain.

• "Terminal condition" means an incurable condition caused by injury, disease or illness that according to reasonable medical judgement will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not consider the relative benefits and burdens of treatment. Discuss your wishes with your physician, family or other important people in your life.
**Medical Power of Attorney**

**THIS IS AN IMPORTANT LEGAL DOCUMENT. YOU SHOULD KNOW THESE IMPORTANT FACTS:**

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all healthcare decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them for yourself.

Because “health care” means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of healthcare decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent’s instructions or allow you to be transferred to another physician.

Your agent’s authority begins when your doctor certifies that you lack the capacity to make healthcare decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have.

It is important that you discuss this document with your physician or other healthcare providers before you sign it, to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and who can answer your questions. You do not need a lawyer’s assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as your healthcare agent should be someone you know and trust. The person must be 18 years of age or older, or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider. The law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your healthcare agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for healthcare decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make healthcare decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, or by your execution of a subsequent Medical Power of Attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

**LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:**

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make healthcare decisions for you.

**THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING MAY NOT ACT AS ONE OF THE WITNESSES:**

1. The person you have designated as your agent;
2. A person related to you by blood or marriage;
3. A person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
4. Your attending physician;
5. An employee of your attending physician;
6. An employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner or business office employee of the health care facility or of any parent organization of the health care facility; or
7. A person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

**Designation of a Health Care Agent**

I, ______________________ (insert your name), appoint:

Name: ____________________________

Address: _________________________

City, State, Zip: ____________________ Phone: _________________________

as my agent to make any and all healthcare decisions for me, except to the extent I state otherwise in this document. This Medical Power of Attorney takes effect if I become unable to make my own healthcare decisions and this fact is certified in writing by my physician.

**SIGNATURES OF WITNESSES**

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________
Designation of an Alternate Agent

You are not required to designate an alternate agent, but you may do so. An alternate agent may make the same healthcare decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved. If the person designated as your agent is unable or unwilling to make healthcare decisions for me, I designate the following person(s) to serve as my agent, to make the healthcare decisions for me authorized by this document, who serve in the following order:

A. First Alternate Agent

Name: ______________________________________________________________________________________________
Address: ____________________________________________________________________________________________
City, State, Zip: ______________________________________________ Phone: ________________________________

B. Second Alternate Agent

Name: ______________________________________________________________________________________________
Address: ____________________________________________________________________________________________
City, State, Zip: ______________________________________________ Phone: ________________________________

The original of this document is kept at:
____________________________________________________________________________________________________
____________________________________________________________________________________________________

The following individuals or institutions have signed copies:

Name: ______________________________________________________________________________________________
Address: ____________________________________________________________________________________________
City, State, Zip: ______________________________________________ Phone: ________________________________

Name: ______________________________________________________________________________________________
Address: ____________________________________________________________________________________________
City, State, Zip: ______________________________________________ Phone: ________________________________

Duration

I understand that this Power of Attorney exists indefinitely from the date I execute this document unless I established a shorter time to revoke the Power of Attorney. If I am unable to make healthcare decisions for myself when this Power of Attorney expires, the authority I have granted my agent continues to exist until the time I become able to make healthcare decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: __________________________________________

PRIOR DESIGNATIONS REVOKED I revoked any prior Medical Power of Attorney.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT I have been provided with a disclosure statement explaining the effect of this document. I have read and understood the information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS MEDICAL POWER OF ATTORNEY) I sign my name to this Medical Power of Attorney:

on _______ day of _______ (month), _______ (year) at _______ a.m./p.m.
in _____________________________________________________________ (City and State)

______________________________________________  ______________________________________________
(Signature) (Print name)

STATEMENT OF FIRST WITNESS

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal’s estate on the principal’s death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal’s estate on the principal’s death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner or business office employee of the health care facility or of any parent organization of the health care facility.

First Witness:
Signature: _______________________________________________________________
Printed name: ____________________________________________________________ Date: _____________________

Second Witness:
Signature: _______________________________________________________________
Printed name: ____________________________________________________________ Date: _____________________