

NURSING HOME CALL SHEET

Patient Name: _____ Weight: _____

Surgery Date: _____

Contact Person at Facility: _____

Facility Phone Number: _____

Fax Number: _____

Preop Phone Call Date: _____

Transportation: Wheelchair Stretcher

Transportation Company Number: _____

OR

Family Transport: _____ Telephone: _____

POA: Yes (must sign consent) No

POA: Name: _____

Surgical Consent Done: Yes (placed on chart) No

Can the patient bear weight? Yes No (come by stretcher)

Is the patient cooperative? Yes No

Notes:



81 Sylvania Drive
Dayton, OH 45440
(937) 431-9531-Facility
(937) 431-1518-PAT
(937) 431-9532-Fax

Pre-Surgical Instructions for Nursing Home Patients

Date: ____ / ____ / ____

Attn: _____

Facility: _____

Phone #: _____ Fax #: _____

From: Pre-Admission Nurse Phone #: (937) 431-1518 Fax #: (937) 431-9532

Patient Name: _____

Date of Surgery: ____ / ____ / ____

Patient needs to arrive at the surgery center by: _____ AM PM

What patient needs to bring with them day of surgery:

- Please send a copy of the patient's **DURABLE POWER of ATTORNEY** and medical insurance cards/information with the patient.

Eating and Drinking Instructions:

- **NO FOOD AFTER MIDNIGHT.**
- Sips of water with *morning* medications.
- The patient should take the following medications the A.M. of surgery with *sips of water ONLY*:

_____	_____
_____	_____
_____	_____

Insulin Instructions:

- If blood sugar is **BELOW 100** or **GREATER than 300**, call (937) 431-9531, Option # 3, and ask for a pre-op nurse. The nurse is available after 6am.

Other Important Instructions:

- Have patient wear comfortable clothing. The top must be **short sleeve** & button down the front or have a loose neckline.
- **Dentures** or **partials** may be worn if they are a *good fit*.
- Wash face the morning of surgery. **NO MAKE-UP. NO LOTIONS. NO PERFUME.**
- Jewelry and all other valuables should be left at the nursing facility.

THANK YOU!!

PREADMISSION NURSE

PLEASE SEND THIS FORM WITH PATIENT DAY OF SURGERY:

Patient Name: _____

1. NPO STATUS:

Time of last solid food: _____

Time of last oral liquids: _____

Last weight recorded on patient's chart: _____

2. A.M. MEDICATIONS GIVEN DAY OF SURGERY:

3. Date of last ASPIRIN: _____

Date of last **BLOOD THINNER:** _____

4. Name of contact person at the Nursing Facility n the day of surgery that we may contact with questions.

Name: _____ Phone #: _____

Thank you,

Preadmission Nurse

Dayton Eye Surgery Center