



HALTON UROLOGY

Dr. Kevin G. Kwan, BSc (Hons), MD, FRCS(C)

Minimally Invasive Surgery and General Urology
Assistant Clinical Professor, Division of Urology
Department of Surgery, McMaster University
Chief of Surgery, Milton District Hospital, Halton Healthcare

Dr. Eric B. Cole, BSc, MD, FRCS(C)

Endourology, Minimally Invasive Surgery and General Urology
Assistant Clinical Professor, Division of Urology
Department of Surgery, McMaster University

Halton Healthcare • Georgetown Hospital • Milton District Hospital • Oakville Trafalgar Memorial Hospital

Suite 205 - 311 Commercial Street • Milton • Ontario • L9T 3Z9 • Tel: (905) 875-3920 • Fax: (905) 875-4340
Email: office@haltonurology.com • Web: www.haltonurology.com

To **AVOID** cancellation of your surgery, please read and follow the instructions below. Bring your health card and this **COMPLETED** envelope with you to ALL your appointments.

1. Your SURGERY is booked at the **Milton District Hospital - Surgical and Procedures unit** (725 Bronte Street South, Milton, Ontario - use Main Entrance) on:

Surgery Date and Time: _____ **at** _____

- ▶ YOU MUST arrange for a responsible adult to drive you home and stay with you for 24 hours after your surgery
- ▶ Please arrive 2 hours prior to your appointment time for surgery (unless you are booked at 0800, arrive at 0630) to register at the hospital and be prepared for surgery
- ▶ If there is a required change or adjustment in the time or date of your surgery, my office will contact you directly
- ▶ If you require a change or cancellation of your surgery, **there may be a fee of \$300 charged to you to have your surgery rebooked at the discretion of your surgeon**
- ▶ Before your surgery, you will require a pre-operative clinic appointment at the hospital. The pre-operative appointment is important to prepare you for surgery. At this appointment you will review your surgery and health history and meet with the anesthesiologist if necessary. **If you do not attend your Pre-Operative Clinic visit, your surgery will be cancelled by the hospital.**

2. Please bring the following with you to your Pre-Operative Clinic visit:

Item	Details
Your Pre-Admission Clinic Package	Given to you by the surgeon.
Pre-Operative Surgical Questionnaire	Completed by you BEFORE your pre-operative visit.
Cumulative Patient Profile (CPP)	Please obtain from your family doctor.
Medication List from your pharmacy or your medications in their original containers	
Your Ontario Health card	

3. The Pre-Operative Clinic will contact you by phone to arrange an appointment prior to your surgery.

The clinic is located at the Milton District Hospital - Pre-admission clinic - North Block Clinics on the main floor (use Outpatient Entrance near Lot 2) on:

Pre-Operative Clinic Date and Time: _____ **at** _____



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Instructions for before your surgery:

1. Please **DO NOT** have anything to eat or drink **after midnight** the day before your surgery. Otherwise, your surgery will likely be cancelled by the anesthesiologist on the day of surgery for your safety.
 - ▶ You may take your medications with sips of water. If indicated or instructed, you may have clear fluids (e.g. black tea, black coffee, water, apple juice, ginger ale) until 3 hours before your time of surgery.
 - ▶ Please **DO NOT** drink orange juice or milk or any fluid that is not clear.
2. Bring your completed Patient/Family-Recorded Home Medication List form. Bring all your daily medications with you to the hospital in their original pharmacy containers.
3. The Pre-Operative Clinic will give you instructions regarding which of your home medications you are to take and which ones to stop. **If you are not sure, please call my office.**

In general, the time to stop the blood thinner before your surgery: aspirin (3 days), Aggrenox (24hrs), Brillinta (5-7 days), Coumadin (5 days), Eliquis (3 days), Effient (7-10 days), Fragmin (12-24hrs depending on dose), Heparin (4-6hrs), Lovenox (12-24hrs depending on dose), NSAIDS (3 days), Plavix (5-7 days), Pradaxa (5 days), Xarelto (3 days). *****You do not need to stop your blood thinners for kidney stone surgery with Dr. Kwan. You must stop your blood thinners for all other urologic surgeries*****

4. These are the medications to take on the morning of your surgery (you may take this with sips of water):

▶ If you have diabetes, **DO NOT** take your diabetic medications on the morning of surgery.

5. On the morning of your surgery, you may have a shower and wash the area to be operated on. The chlorhexidine – CHD shower instructions should only be used for abdominal surgery (e.g. do not use if you are having stone surgery, endoscopic surgery, or any surgery on the penis, testicles, or vagina)
6. Remove all make-up, lipstick, nail polish, contact lenses, piercings, and jewellery. Please **DO NOT** wear perfume, cologne, or other scented products. The hospital is a fragrance-free hospital environment.
7. **Bring your health card, warm housecoats, socks, and slippers.** Leave all your jewellery and valuables at home. We cannot be responsible for lost or stolen items.

Preparing for Your Surgery



Preparing for your surgery looks very different during the COVID-19 pandemic. Our focus continues to be the health and safety of our patients, visitors, staff and physicians.

We want you to have the best outcome for your surgery. Please refer to the "For Your Safety" list of things you can do the help ensure you are well prepared for your surgery.



Before your surgery

Our Pre-Admission Clinic will contact you by phone to arrange an appointment prior to your surgery.

When you arrive at the hospital you will be asked a series of questions, given a Visitor sticker and a screening card that you will take with you to your clinic appointment. You will also be asked to clean your hands. We ask that you maintain appropriate physical distancing of 6 feet and follow any COVID-19 signage.

At this appointment you will review your surgery and health history with a nurse and meet with the anesthesiologist if necessary. You will be told your surgery time, expected discharge time and will have the opportunity to ask questions.



COVID-19 Testing

Your physician may order a COVID-19 test. The test might be done at your Pre-Admission appointment or on a date closer to your surgery.

You must self isolate from the time of your COVID-19 test until your surgery.

Scheduled surgeries and procedures may be cancelled for patients with suspected or confirmed COVID-19.

For Your Safety

To help you prepare for a successful surgery we recommend you follow these guidelines:

- We recommend that you self-isolate for 14 days prior to your surgery to reduce your risk of infection. This may include limiting contact with family in your household and friends.
- Clean your hands frequently.
- Practice physical distancing.
- Please wear a mask in public when physical distancing is not possible. You and your support person should wear your own masks when you come to the hospital, including homemade cloth masks.
- Contact your surgeon immediately if you develop any of the following COVID-19 symptoms:
 - Fever
 - New onset of cough
 - Worsening chronic cough
 - Shortness of breath
 - Difficulty breathing
 - Sore throat
 - Runny nose
 - Sneezing
 - Nasal congestion
 - Decreased/loss of smell or taste
 - Chills
 - Headache
 - Unexplained fatigue
 - Nausea/Vomiting
 - Diarrhea
 - Abdominal pain
 - Muscle aches
 - Pink eye (conjunctivitis)
 - Hoarse voice or difficulty swallowing

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On the Day of Your Surgery

Unless otherwise directed by your healthcare provider, please arrive at the hospital **2 hours prior to your scheduled surgery time**.

Do not arrive earlier than this time. We are doing our best to ensure physical distancing in our waiting rooms and clinics. If you arrive too early you will be asked to wait in your vehicle.

When you arrive at the hospital entrance you will go through the screening process and proceed to the Surgical area of the hospital.

When you register in the Surgical department, please ensure that the contact information for your support person is accurate. In most cases, surgeons will provide updates to your support person using the telephone contact information that has been provided.



Visitor Restrictions

We recognize that some individuals may require a support person to accompany them to the hospital. While we are currently limiting the number of people who are coming into our buildings due to COVID-19, we continue to accommodate the need for support persons where it is safe to do so.

Our waiting rooms have been updated to ensure we are able to safely, physically distance and this may impact our ability to accommodate everyone. Some support people may be asked to wait in their vehicles, those who are able to stay will be asked to remain in the designated waiting room until the patient is discharged. Please speak to your healthcare team for more information.



Overnight stays

If you are staying overnight, please bring your personal belongings with you when you arrive for surgery. They will be taken to your room on an inpatient unit after your surgery. Your support person will not be permitted to visit you while you are an inpatient.



Do Your Part to Keep Everyone Safe

Please respect the physical distancing measures and signage put in place to keep our patients, visitors, staff and physicians safe. This includes standing in line to enter the hospital, as well as in the food court, elevators and waiting areas.

June 15, 2020

For the latest updates on our COVID-19 precautions, please visit www.haltonhealthcare.com



PRE-OP SURGICAL QUESTIONNAIRE

GENERAL INFORMATION

Your name: _____
Last Name First Name

By what name should we call you: _____ What is your date of birth? _____

Age: _____ Your current height: _____ Your current weight: _____

Home phone: () _____ Cell Phone: () _____

Email: _____

Surgeon: _____ Family Doctor: _____

Who is your primary contact person?

Name/Relationship: _____ Phone: _____

Who will take you home and stay with you after discharge from the hospital?

Name/Relationship: _____

Have you had previous operations? (Including C-sections). If YES, list below

Operations	Anaesthetic type, if known (general/spinal/epidural/local)	Hospital	Anaesthetic Problems
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		

ALLERGIES

Do you have an allergy to Latex? Yes No Unknown

Do you have allergies and/or intolerances, adverse reactions? (i.e. medication, tape, food, etc.) if yes, please list below

Allergic to:	Reaction:

PRE-OP SURGICAL QUESTIONNAIRE

Anaesthetic History	Have you or any blood relatives in your family ever had a bad reaction to anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Is there a family history of Malignant Hyperthermia (high fever) during anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Have you ever been told of difficulty with placement of breathing tube during anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Do you have pain/stiffness in your neck/jaw (TMJ)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Do you have pain/stiffness in your lower back?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Do you have any loose teeth, capped teeth, braces, retainers, or dentures? (please circle appropriate response)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Do you have difficulty opening your mouth fully?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Have you had confusion after surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Are you, or could you be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

HOME MEDICATIONS

Please complete the "Patient/Family Recorded Home Medication List" Form # H3760

Do you take Warfarin, Coumadin, Aspirin, Plavix, or any blood thinner? Yes No Unknown

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THESE FOLLOWING PROBLEMS?

(select all that apply)

Heart Health	<input type="checkbox"/> Heart attack <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Angina/Chest Pain <input type="checkbox"/> Blockages <input type="checkbox"/> Stent/Angioplasty <input type="checkbox"/> Valve Problems <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Failure <input type="checkbox"/> Pacemaker or implantable defibrillator <input type="checkbox"/> Other:	
	Do you have high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Have you had any recent heart tests in the last 2 years? (Not ECG) (e.g. stress test, holter monitor, echocardiogram)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Can you do the following at a normal pace without stopping?	
	Walk 1 block	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Climb one flight of stairs	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you feel short of breath when lying flat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had blackouts or fainting spells?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Have you ever been told you have an aneurysm?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Have you seen a Cardiologist in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiologist's name: _____ Phone: _____		

PRE-OP SURGICAL QUESTIONNAIRE

Respiratory Health	<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other:	
	Do you use oxygen at home to help you breathe?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Have you seen a respirologist in the past 2 years? Respirologist's Name: _____ Phone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have sleep apnea? (diagnosed by a sleep study) If yes, is it:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
	Was a CPAP machine recommended for you? If yes, what is your CPAP setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
	If you answered no or unknown to having sleep apnea: Do you snore loudly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you often feel tired, fatigued, or sleepy during the daytime? Has anyone observed you stop breathing or choking/gasping during your sleep? Do you have or are being treated for high blood pressure? Are you older than 50 years old? Gender = male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
FOR CLINIC USE ONLY	STOPBANG Score:	

Endocrine and Metabolic Health	Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	If you have diabetes, how do you manage it?	<input type="checkbox"/> Insulin <input type="checkbox"/> Diabetic Pills <input type="checkbox"/> Diet only
	Do you have thyroid problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Other:	

Stomach and Intestinal Health	<input type="checkbox"/> Feeding Tube <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Hiatus Hernia (stomach) <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Liver Disease (e.g. hepatitis, jaundice) <input type="checkbox"/> Other	
	Do you have difficulty eating or swallowing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any nausea, vomiting, choking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you currently have an ostomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRE-OP SURGICAL QUESTIONNAIRE

Blood Health	<input type="checkbox"/> A diagnosed blood disorder Type: _____ <input type="checkbox"/> Sickle cell trait <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Anemia (low blood count) <input type="checkbox"/> A blood clot (in lungs, legs, or elsewhere) <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other: _____	
	Have you received blood or blood products in the last 3 months? Have you ever had a blood transfusion? Total number of pregnancies: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Do you have any personal or religious reasons to decline blood or blood products?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Have you seen a specialist for any of the above in the past 2 years? Specialist name: _____ Phone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Kidney and Bladder Health	Do you have Kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Are you on dialysis? If yes, please select all that apply: <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Have you seen a nephrologist in the past 2 years? Nephrologist's name: _____ Phone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Nerve, Muscle and Bone Health	<input type="checkbox"/> A disease that affects your muscles/nerves (e.g. Multiple sclerosis, Parkinson's, ALS) <input type="checkbox"/> A stroke or stroke-like symptoms <input type="checkbox"/> A brain aneurysm <input type="checkbox"/> Spinal cord problems (e.g. spinal stenosis, scoliosis) <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> A seizure disorder (e.g. epilepsy) <input type="checkbox"/> Dementia <input type="checkbox"/> Fainting spells, vertigo in the past 2 years <input type="checkbox"/> Migranes <input type="checkbox"/> Neuropathy <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Creutzfeldt-Jakob Disease (CJD) <input type="checkbox"/> Other: _____	
	Have you ever been diagnosed with: <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Anklosing spondylitis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Other _____ <input type="checkbox"/> None of the above	
	Have you seen a neurologist and/or rheumatologist for any of the above in the past 2 years? Specialist's name: _____ Phone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRE-OP SURGICAL QUESTIONNAIRE

Other	Have you had overnight hospitalization within the past year? If yes, please state why:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have a history of Mental Health issues? If yes, please state:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you use any ambulatory aids? If yes, please select all that apply: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutches	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had cancer? If yes, please select all the treatments that apply: <input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you taking pain killers regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you smoke or vape any of the following products? <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Marijuana Number per day: Number of years: Quit date:	
	Do you drink alcohol? If yes, how many drinks per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever taken recreational drugs? (e.g. cocaine, heroin, marijuana)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you currently take recreational drugs? If yes, when was the last time taken?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any body piercings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any additional health issues/concerns we should be aware of before your surgery?		

I confirm the information provided in this document is accurate to the best of my recollection and abilities.

Signature of Patient

Date

Signature of Substitute Decision Maker (if required)

Substitute Decision Maker Name (Print)

Relationship to Patient

Patient Instructions

Preventing Surgical Site Infections

Fact Sheet for Surgical Patients and Families

This fact sheet provides basic information only. It must not take the place of medical advice, diagnosis or treatment. Always talk to your health care professional about any health concerns you have, and before you make any changes to your diet, lifestyle or treatment.

What Are Surgical Site Infections (SSIs)?

Surgical site infections occur when harmful germs or bacteria enter your body through the surgical site (any cut the surgeon makes in the skin to perform the operation). Infections happen because germs are everywhere - on your skin, in the air and on things you touch. Most infections are caused by germs found on and in your body. This fact sheet describes some measures we can all take to prevent SSIs but, despite all prevention efforts, they can sometimes still occur.

What Are The Symptoms of SSIs?

- Increased soreness, pain, or tenderness at the surgical site
- A red streak, increased redness, or puffiness near the incision
- Greenish-yellow or bad-smelling discharge from the incision
- Fever of 101 degrees Fahrenheit or 38 degrees Centigrade or higher
- A tired feeling that won't go away

Symptoms can appear at any time from hours to weeks after surgery. Implants such as an artificial knee or hip can become infected a year or more after the operation. Make sure you contact your health care provider if you suspect you have an infection.

What Are The Risk Factors For SSIs?

The risk of acquiring a surgical site infection is higher if you:

- are an older adult;
- smoke;
- have a weakened immune system or other serious health problem such as diabetes;
- are malnourished (don't eat enough healthy food);
- are very overweight

Preventing Surgical Site Infections

What Is Being Done To Prevent SSIs?

The following precautions to prevent SSIs are being taken by your healthcare providers:

You can help too (see number 6 and 7 below)!

1. Practicing proper hand washing techniques. Before the operation, the surgeon and all the operating room staff scrub their hands and arms with an antiseptic soap.
2. Cleaning the site where your incision is made with an antiseptic solution.
3. Wearing medical uniforms (scrub suits), long-sleeved surgical gowns, masks, caps, shoe covers and sterile gloves.
4. Covering you with a sterile drape with a hole where the incision will be made.
5. Giving you an antibiotic preoperatively, if needed.
6. Closely watching your blood sugar levels very carefully, especially if you are a diabetic. Keeping them within a normal range helps to support good wound healing.
7. Keeping you warm before, during and after your operation is important. Maintaining a close to normal body temperature ensures good oxygenation of the tissues and this promotes wound healing.

Warmed IV fluids and warm blankets are available and may be provided by the hospital staff.

You can help keep yourself warm before the procedure by bringing in warm socks or slippers.

8. Do not shave hair from the incision site or use a hair removal product! If hair must be removed, the surgeon makes this decision and special clippers, which do not touch the skin, are used to remove hair. You can help by **not shaving the area of the incision for at least 1 week prior to your surgery!**



CHLORHEXIDINE – CHD SHOWER INSTRUCTIONS BEFORE SURGERY

Department of Surgery



Purchase one 4oz (115mL) bottle
Chlorhexidine gluconate 4% (CHD)
from your local pharmacy


DIRECTIONS:

Take **TWO** showers, **one** the **night before surgery** and **another** the **morning of surgery**

1. Remove all jewelry and body piercings.
2. Wash your hair and body using your normal soap and shampoo. Rinse. Step away from the water.
3. Wet a clean washcloth and apply **CHD** solution to the wet washcloth. Use half of the **CHD** for the first shower and half for the next one.
4. Wash your entire body **from the neck down** using the wet, soapy washcloth. Clean your belly button thoroughly with Q-tips and **CHD**, (wash your outer genital and anal areas last). Leave the solution on the skin for **3 minutes**, then rinse the cleaner thoroughly from your body.
5. Use a clean towel to pat your skin dry.
6. Dress in fresh clean sleepwear/clothes. Sleep in clean sheets the night before your surgery.

**If you have any questions or concerns,
contact your surgeon**

 **DO NOT!**

➤ **Do not use** the Chlorhexidine  **near your eyes, ears, mouth or vagina**

➤ **Do not use** if you are allergic to Chlorhexidine; consult your surgeon

➤ **Do not** apply body moisturizing lotion or powder after your shower

➤ **Do not** shave, clip, or wax below your neck for 7 days before surgery

 **IMPORTANT!**

➤ If you experience any **signs of allergy**, for example, a rash, breathing difficulties, palpitations, or swelling of the lips, tongue and throat, or if you feel unwell in any way, **STOP** use and please seek medical advice immediately, visit your Emergency Department, family doctor, or call Telehealth Ontario (1-866-797-0000) or 911



Patient / Family-Recorded Home Medication List

Date Recorded: _____

Pharmacy name and phone number: _____

Allergies (Describe Reaction): No Known Allergies

Currently Taking Medications / Supplements at Home?
 No Unknown

When do you take your medications?

Medication Name	Dose or Strength	A.M.	Noon	P.M.	Bedtime	Other	As Needed



COMPLETED BY: Patient Family Health Care Professional

Patient / Family-Recorded Home Medication List

Why create a Home Medication List?

Your Home Medication List is a tool to help you and your family keep track of all the medications you are taking. It is important to write down everything, including vitamins and supplements, so your healthcare team can provide you with the best possible care. Certain medications might interact with another medication on your list; so, it is important that your Home Medication List be correct and up-to-date.

Instructions for Patient or Family:

1. List **ALL** prescription medications, non-prescription medications, vitamins, herbal and naturopathic products, and/or drug trials.
2. Write the dosage of each medication.
3. For each medication write the number of pills you take at the listed times. See examples.
 - If your medication time is not listed, write the time you take it in the “Other” column
4. If the name of medication is unknown, describe pill under “Medication Name”, and indicate why you are taking it.
5. Your list will be photocopied and put on your hospital file.
6. Always keep a copy of your *Home Medication List* with you.
7. If you stop taking something or start a new medication, be sure to update this list.
8. If you have any questions about your medication or filling out this form, contact your doctor or pharmacist.

EXAMPLES:

Medication Name	Dose or Strength	AM	Noon	PM	Bedtime	Other	As Needed
Metformin	500mg	2		2			
Tylenol Arthritis	650mg					1 at 10:30 am	
Natural Tears	1 drop in left eye						√
Hydrocortisone Cream	0.1% To arm				1		
Vitamin D	1000 units	1					

