Preparing for Your Surgery

Halton Healthcare

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

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.

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

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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
	❒ General ❒ Local ❒ Spinal/epidural		
	❒ General ❒ Local ❒ Spinal/epidural		
	❒ General ❒ Local ❒ Spinal/epidural		
	❒ General ❒ Local ❒ Spinal/epidural		
	❒ General ❒ Local ❒ Spinal/epidural		
	❒ General ❒ Local ❒ Spinal/epidural		
	❒ General ❒ Local ❒ 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:

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Anaesthetic History	Have you or any blood relatives in your family ever had a bad reaction to anaesthetic?	❒ Yes ❒ No ❒ Unknown
	Is there a family history of Malignant Hyperthermia (high fever) during anaesthetic?	❒ Yes ❒ No ❒ Unknown
	Have you ever been told of difficulty with placement of breathing tube during anaesthetic?	❒ Yes ❒ No ❒ Unknown
	Do you have pain/stiffness in your neck/jaw (TMJ)?	❒ Yes ❒ No ❒ Unknown
	Do you have pain/stiffness in your lower back?	❒ Yes ❒ No ❒ Unknown
	Do you have any loose teeth, capped teeth, braces, retainers, or dentures? (please circle appropriate response)	❒ Yes ❒ No ❒ Unknown
	Do you have difficulty opening your mouth fully?	❒ Yes ❒ No ❒ Unknown
	Have you had confusion after surgery?	❒ Yes ❒ No ❒ Unknown
	Are you, or could you be pregnant?	❒ Yes ❒ No ❒ 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	❒ Heart attack ❒ Heart Murmur ❒ Angina/Chest Pain ❒ Blockages ❒ Stent/Angioplasty ❒ Valve Problems ❒ Peripheral Vascular Disease ❒ Heart Surgery ❒ Irregular Heartbeat ❒ Heart Failure ❒ Pacemaker or implantable defibrillator ❒Other:	
	Do you have high blood pressure?	❒ Yes ❒ No ❒ Unknown
	Have you had any recent heart tests in the last 2 years? (Not ECG) (e.g. stress test, holter monitor, echocardiogram)	❒ Yes ❒ No ❒ Unknown
	Can you do the following at a normal pace without stopping? Walk 1 block Climb one flight of stairs	 ❒ Yes ❒ No ❒ Yes ❒ No
	Do you feel short of breath when lying flat?	❒ Yes ❒ No
	Have you ever had blackouts or fainting spells?	❒ Yes ❒ No ❒ Unknown
	Have you ever been told you have an aneurysm?	❒ Yes ❒ No ❒ Unknown
	Have you seen a Cardiologist in the past 2 years? Cardiologist's name: Phone:	❒ Yes ❒ No

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Respiratory Health	❒ Asthma ❒ Chronic Obstructive Pulmonary Disease (COPD) ❒ Tuberculosis (TB) ❒ Tracheostomy ❒ Other:	
	Do you use oxygen at home to help you breathe?	❒ Yes ❒ No ❒ Unknown
	Have you seen a respirologist in the past 2 years? Respirologist's Name:_____Phone:_____	❒ Yes ❒ No
	Do you have sleep apnea? (diagnosed by a sleep study) If yes, is it:	❒ Yes ❒ No ❒ Unknown ❒ Mild ❒ Moderate ❒ Severe
	Was a CPAP machine recommended for you? If yes, what is your CPAP setting?	❒ Yes ❒ No _____
	If you answered no or unknown to having sleep apnea: Do you snore loudly? 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	 ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No
	FOR CLINIC USE ONLY	STOPBANG Score:

Endocrine and Metabolic Health	Do you have diabetes?	❒ Yes ❒ No ❒ Unknown
	If you have diabetes, how do you manage it?	❒ Insulin ❒ Diabetic Pills ❒ Diet only
	Do you have thyroid problems?	❒ Yes ❒ No ❒ Unknown
	Other:	

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

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

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

Nerve, Muscle and Bone Health	❒ A disease that affects your muscles/nerves (e.g. Multiple sclerosis, Parkinson's, ALS) ❒ A stroke or stroke-like symptoms ❒ A brain aneurysm ❒ Spinal cord problems (e.g. spinal stenosis, scoliosis) ❒ Fibromyalgia ❒ A seizure disorder (e.g. epilepsy) ❒ Dementia ❒ Fainting spells, vertigo in the past 2 years ❒ Migranes ❒ Neuropathy ❒ Alzheimer's Disease ❒ Creutzfeldt-Jakob Disease (CJD) ❒ Other:	
	Have you ever been diagnosed with: ❒ Osteoarthitis ❒ Anklosing spondylitis ❒ Rheumatoid arthritis ❒ Other _____ ❒ 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: _____	❒ Yes ❒ No

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

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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

Georgetown Hospital, 1 Princess Anne Dr., Georgetown, ON L7G 2B8 (905) 873-0111 Fax: (905) 873-4575
Milton District Hospital, 725 Bronte St. S., Milton, ON L9T 9K1 (905) 878-2383 Fax: (905) 878-0498
Oakville Trafalgar Memorial Hospital, 3001 Hospital Gate, Oakville, ON L6M 0L8 (905) 845-2571 Fax: (905) 338-4636

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Patient Instructions

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!**

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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

If you have your own medication list with you, you do not have to fill out this form.

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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

H3760-MED

COMPLETED BY: ❒ Patient ❒ Family ❒ Health Care Professional

Help Us Keep You Safe – Know Your Medications!

See over →

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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					

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Help Us Keep You Safe – Know Your Medications!