Pre-Operative Pack Instructions

Review the following:

Map
- Your pre-operative testing and teaching appointment with Marita is at the Jeffrey M. Carlton, Heart and Vascular Center, Building 31.

Patient Medication List
- All patients need to complete a new Medication List for every visit to the hospital. They need to include all over-the-counter medications, vitamins and herbs.
- Please bring all your medication bottles in a baggie for the nurse to review.

Patient History Questionnaire
- If the patient has completed this form in the last 3 months, they can skip this form.

Pulmonary Function Testing Questionnaire
- Complete the form down to the dark black line.
- They do not need to re-write their medication list; instead they can write “see attached list.” We will attach a copy of their medication list at the pre-op appointment.

Advance Health Care Directive (AHCD)
- It is a state law that we offer you an advance Health Care Directive which is attached. It is a good idea to have one completed and on file at Hoag for your surgery.
- Part I of the form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions. Part 2 of the form lets you give specific instructions about any aspect of your health care.
- If you already have an AHCD at home, please obtain a copy and bring to your pre-operative education appointment.
- It is not required that you complete the AHCH but it is recommended.
- Make sure you follow the instructions on the form carefully. Note that you either need the signature of 2 witnesses (who are not your designated agent) or a notary.

SF-12 Health Survey
- Only patients who are undergoing mitral valve repair surgery need to complete this list.
Scheduling Surgery and
Pre-Op Testing & Teaching Appointment

You are scheduled for surgery on _________________

- Arrival time: ___________________
- Surgery Scheduler’s number: (949) 650-3350.

Pre-operative Testing and Teaching Appointment _________________

- Arrival time: ___________________
- Location: Hoag Heart and Vascular Institute, Building #21.
- Pre-op Scheduler’s number: (949) 764-8258.
- This appointment is usually 7-10 days before your surgery and **takes an average of 3-4 hours**.
- The pre-op nurse will review pre-op instructions, medication regime prior to surgery, skin prep and nasal decontamination.
- **Family members** who will care for you after surgery are encouraged to attend this educational session.
- Immediately after your meeting with our pre-op nurse, you will be directed to different departments to complete any testing required for your surgery (i.e. blood work, EKG, pulmonary testing, chest x-ray).
- **You do not need to fast** for your pre-operative tests (unless a CT scan is scheduled).
- Note we will need a **urine specimen**. Let us know if you need to void when you arrive.

Prior to the pre-op appointment please do the following:

- Read the material in your **Surgery Instruction folder**
  - Watch the **4 pre-op educational videos** located on our website
    http://www.hoag.org/cv-appointment
  - Please only use the following supported browsers to view the videos:

  ![Google Chrome](https://via.placeholder.com/150)
  ![Mozilla Firefox](https://via.placeholder.com/150)
  ![Safari](https://via.placeholder.com/150)

*Internet Explorer is NOT supported*
- If you cannot view the videos, please come to your pre-op appointment 15 minutes early and we will show you the videos here
- You may receive an email from the “CPS Department” with the video link and link to paperwork.
- Complete the attached Pre-operative Packet and bring with you to the pre-op appointment.

**Clearance for surgery**
- Obtain clearance from your dentist (form attached)
  - If you are having valve surgery this is a must!
  - **See your dentist ASAP as many patients have had to have their surgery postponed because they couldn’t be cleared in time.**
- Obtain clearance from the following doctors:

---

**The following tests or procedures need to be completed prior to surgery (i.e. coronary angiogram):**

---

**Frequently Asked Questions about Blood Donation**
- Blood may be needed during or after your surgery. Although some patients are able to donate their own blood prior to surgery others should not donate because of their health status or timing of their surgery. Donating blood before your surgery can be expensive and time-consuming. In general, the surgeons have decided to utilize blood donated by volunteer donors to our Blood Donor Center. The blood from the Blood Donor Center is tested for infectious diseases and the surgeons feel it is safe.
- Knowing the above, if you would still like to pursue donating your own blood in preparation for your surgery, please discuss with your surgeon (or their nurse) if this is a reasonable option so arrangements can be made. In general, we don’t want you to donate close to your surgery date as it will likely make you anemic. (See attached Blood Donation FAQ sheet).

**Herbal List**
- (See attached list)
- Many herbals have possible side-effects that could interfere with your surgery.
- The herbals listed need to be stopped 14 days before surgery.
The accuracy of this information is important to the safety of your care.

Patient Name: _______________________________________
Date of Birth: _____________ Age: _________________
Stated Height: ________________ Stated Weight: ___________
Primary Language: ______________________ Interpreter Needed? □ Yes □ No For which language? ___________
Contact Person: ___________ Telephone #’s: Home (     ) ____________ Work (     ) ____________ Cell (     ) __________
Primary Care Physician: _______________________________________________________________________________
Internist: ______________________ Last seen: ________ Cardiologist: ________________ Last seen: ______________

ALLERGIES and ALLERGIC REACTIONS:

Please check if you have had any of the following CARDIAC/MEDICAL procedures:

☐ Angioplasty/Stent Placement Year Where test/procedure done
☐ Echocardiogram
☐ Stress Test
☐ Pacemaker/Defibrillator (model/brand #)
☐ Other, please specify:

Please check if you have been told you have had any of the following health issues:

CARDIOVASCULAR
☐ Hypertension ☐ Heart Valve Problems ☐ High Cholesterol
☐ Heart Attack – Date: ________
☐ Coronary Artery Disease ☐ Heart Murmур
☐ Cardiomyopathy ☐ Carotid Artery Disease
☐ Congestive Heart Failure ☐ Angina/Chest Pain – Date: ________
☐ Arrhythmias, i.e., A-Fib ☐ Pain or shortness of breath when
☐ Rheumatic Fever walking 2 blocks or climbing 1 flight
☐ of stairs

Age of onset:
Father: ________
Mother: ________
Siblings: ________
Please check if you have been told you have had any of the following health issues:

<table>
<thead>
<tr>
<th>PULMONARY</th>
<th>GASTROINTESTINAL</th>
<th>GENITOURINARY</th>
<th>PAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Asthma</td>
<td>□ Hiatal Hernia</td>
<td>□ Urinary Tract Infections</td>
<td>□ Rheumatoid Arthritis</td>
</tr>
<tr>
<td>□ COPD/Bronchitis/Emphysema</td>
<td>□ Ulcers/GERD/Gastric Reflux</td>
<td>□ Kidney Stones</td>
<td>□ Osteoarthritis</td>
</tr>
<tr>
<td>(circle)</td>
<td>(circle)</td>
<td>□ Prostate Disease</td>
<td>□ Chronic Pain</td>
</tr>
<tr>
<td>□ Pneumonia</td>
<td>□ Gallstones</td>
<td>□ Penile Prosthesis</td>
<td>□ Treatment</td>
</tr>
<tr>
<td>□ Tuberculosis</td>
<td>□ Liver Disease</td>
<td>□ Dialysis</td>
<td>□ Back/Neck Pain</td>
</tr>
<tr>
<td>□ Blood clots in lungs or legs</td>
<td>□ Hepatitis A, B, or C</td>
<td></td>
<td>□ Artificial Joints</td>
</tr>
<tr>
<td>□ Sleep Apnea</td>
<td></td>
<td></td>
<td>□ Artificial Joints</td>
</tr>
<tr>
<td>□ CPAP</td>
<td></td>
<td></td>
<td>□ Location:</td>
</tr>
<tr>
<td>□ Chronic Cough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Oxygen Use</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEMATOLOGIC</th>
<th>ENDOCRINE</th>
<th>NEUROLOGIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Anemia</td>
<td>□ Diabetes</td>
<td>□ Stroke/mini stroke</td>
</tr>
<tr>
<td>□ Bleeding Disorders</td>
<td>□ Hypo/Hyperthyroidism</td>
<td>□ Seizures</td>
</tr>
<tr>
<td>□ Blood Diseases, i.e., Leukemia</td>
<td>□ Hypoglycemia</td>
<td>□ Multiple Sclerosis</td>
</tr>
<tr>
<td>□ Blood Transfusions</td>
<td></td>
<td>□ Myasthenia Gravis</td>
</tr>
<tr>
<td>□ Easy Bruising</td>
<td></td>
<td>□ Paralysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please check appropriate box in each section below:

**GENERAL HEALTHCARE**

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Social History:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location: ______________________</td>
<td>Do you drink alcohol? Amount: ________</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Do you smoke?</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Did you ever smoke? Years: __________</td>
</tr>
<tr>
<td>Immune Deficiency</td>
<td>Have you smoked in the past 12 months?</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (circle)</td>
<td>Do you use recreational drugs?</td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>Type: ______________________________</td>
</tr>
<tr>
<td>Have you had:</td>
<td>History of Malignant Hyperthermia (MH)</td>
</tr>
<tr>
<td>MMR Vaccine</td>
<td>Family history of anesthesia problems</td>
</tr>
<tr>
<td>Flu Vaccine – Date: ____________</td>
<td>or MH (circle)</td>
</tr>
<tr>
<td>Pneumonia Vaccine – Year: _____</td>
<td></td>
</tr>
<tr>
<td>TB Skin Test</td>
<td>If female: possibility of pregnancy?</td>
</tr>
<tr>
<td>Positive</td>
<td>Last menstrual period:</td>
</tr>
<tr>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

**SURGICAL INFORMATION**

Do you have specific needs?  
<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: __________________________</td>
<td></td>
</tr>
</tbody>
</table>

Do you need information on:  
<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current surgery</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Activities</td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td></td>
</tr>
<tr>
<td>Do you wear contact lenses?</td>
<td></td>
</tr>
<tr>
<td>Do you have caps, bridges, dentures, or loose teeth?</td>
<td></td>
</tr>
</tbody>
</table>

[Patient/Parent/Conservator/Guardian] [Date] [Time]  
[If completed by other than patient, indicate relationship]  
[Reviewed by Assessment Nurse] [Date] [Time]  
[Reviewed by Procedure Nurse] [Date] [Time]  
[Reviewed by PACU Nurse] [Date] [Time]  
[Reviewed by Discharge Nurse] [Date] [Time]
## Acknowledgement

I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information.

BRING THIS FORM WITH YOU TO HOAG.

**Check this box if not on any home medications.**

**DESCRIBE ALLERGIES & REACTIONS:**

Completed by: __________________________ Date/Time: ______________

Source of Medication History: __________________________________________

<table>
<thead>
<tr>
<th>Continue or Formulary Equivalent (circle one)</th>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Freq</th>
<th>Reason for Taking</th>
<th>Dose last taken - RN to Complete</th>
<th>Stop</th>
<th>Continue (Next Dose)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>2.</td>
<td></td>
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<td></td>
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<td></td>
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<td>Y</td>
<td>3.</td>
<td></td>
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<tr>
<td>Y</td>
<td>4.</td>
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<td></td>
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<tr>
<td>Y</td>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Y</td>
<td>6.</td>
<td></td>
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<tr>
<td>Y</td>
<td>7.</td>
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</tr>
<tr>
<td>Y</td>
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<tr>
<td>Y</td>
<td>9.</td>
<td></td>
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<tr>
<td>Y</td>
<td>10.</td>
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</tr>
</tbody>
</table>

**Medication Reconciliation on Entry:**

Noted: [ ] CC/RN: __________________ Date/Time: __________

[Physician Signature]

**Medication Reconciliation on Discharge:**

Noted: [ ] RN: __________________ Date/Time: __________

[Physician Signature]

Date/Time: __________

ID#: __________________

**DISCHARGE: PRINT NEW MEDICATIONS AND CHANGES TO ABOVE MEDICATIONS (PROVIDE PRESCRIPTION TO PATIENT)**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Freq</th>
<th>Reason</th>
<th>Special Instructions</th>
<th>Medication Schedule</th>
<th>Comments</th>
</tr>
</thead>
</table>

Original to patient on discharge. Line through stopped meds.

Discharge RN: __________________ Date/Time: __________

Discharge Physician Signature: __________________ Date/Time: __________

ID#: __________________

**MEDICATION RECONCILIATION/ORDERS**

Hoag Memorial Hospital Presbyterian

PS 7514

Rev 12/16/10

**PLACE IN FRONT OF PHYSICIAN ORDERS**

Original – Patient

Photocopy 1 – Chart

Photocopy 2 – Primary Care Physician

Page _____ of ____  Patient Name __________________________

[2517]
PULMONARY FUNCTION TESTING QUESTIONNAIRE

To our patient: Please answer the questions below and sign your name at the end. Thank you!

1. Reason for today’s test: ________________________________________________________________

2. Have you ever smoked?  [ ] Yes  [ ] No
   If yes, what did you smoke? (check all that apply)  [ ] Cigarettes  [ ] Cigar  [ ] Pipe  [ ] Other: __________
   How many years did you smoke? __________  How many packs a day did/do you smoke? ___________
   When did you quit smoking? _______________

3. Do you get short of breath when:
   Sitting  [ ] Yes  [ ] No
   Walking normally  [ ] Yes  [ ] No
   Climbing stairs  [ ] Yes  [ ] No

4. Do you have a daily cough?  [ ] Yes  [ ] No
   If yes, any blood in sputum?  [ ] Yes  [ ] No
   If yes, how much sputum per day do you cough up? _______

5. Have you ever had a history of:
   Emphysema  [ ] Yes  [ ] No  Pneumonia  [ ] Yes  [ ] No
   Asthma  [ ] Yes  [ ] No  Heart Disease  [ ] Yes  [ ] No
   Wheezing  [ ] Yes  [ ] No  Bronchiectasis  [ ] Yes  [ ] No
   Bronchitis  [ ] Yes  [ ] No  MRSA  [ ] Yes  [ ] No
   Tuberculosis  [ ] Yes  [ ] No

6. Have you been told that you:
   Snore when you sleep?  [ ] Yes  [ ] No
   Have periods of not breathing while asleep?  [ ] Yes  [ ] No
   Have difficulty staying awake during the daytime?  [ ] Yes  [ ] No

7. Have you had recent surgery of the chest or abdomen?  [ ] Yes  [ ] No

8. Have you ever had a breathing tube in your windpipe for surgery or to help you breathe?  [ ] Yes  [ ] No

9. Have you ever been exposed to dust, fumes, chemicals in a hazardous manner while at work or at home?  [ ] Yes  [ ] No
   If yes, please list your exposure: _____________________________________________________________

10. What medications are you currently taking?  ___________________________________________________
    _______________________________________________________________________________________

11. Have you ever had radiation or chemotherapy?  [ ] Yes  [ ] No
    If yes, please list medication or area of radiation: ______________________________________________

12. Have you ever had a Pulmonary Function Test?  [ ] Yes  [ ] No
    If yes, please list when and where: ____________________________________________________________

_________________________________________________________  ________________________________  ___________ A.M./P.M.
[Patient Signature]  [Date]  [Time]

Date: ____________________________________________ Ordering Physician: _______________________________________
BP: ______  HR: _____  SPO2 _______% on _________  THB: _______ %  CO _______  SAO2 _______%

PRE-OP For:__________________________________________  Date of surgery: ________________________________
PRE-OP Education:  [ ] Intubation/ET Tube  [ ] Incentive Spirometry  [ ] Splinting  [ ] Coughing/Deep breathing
Repeatable Test?  [ ] Yes  [ ] No

Patient Position: ____________________________________
RCP Comments: ____________________________________
RCP Print Name: ____________________________________  RCP Signature: ________________________________

PULMONARY FUNCTION TESTING QUESTIONNAIRE
PS 4117  Rev 03/05/10
Name: ___________________ Date of surgery (if known): ________________

SF-12v2 Health Survey (standard form, 4-week recall)

Your Health and Well-Being

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Thank you for completing this survey! For each of the following questions, please mark an \[ X \] in the one box that best describes your answer.

1. In general, would you say your health is:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>[  ]</td>
<td>[  ]</td>
<td>[  ]</td>
<td>[  ]</td>
<td>[  ]</td>
</tr>
<tr>
<td>[ 1 ]</td>
<td>[ 2 ]</td>
<td>[ 3 ]</td>
<td>[ 4 ]</td>
<td>[ 5 ]</td>
</tr>
</tbody>
</table>

2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

<table>
<thead>
<tr>
<th>Yes, limited a lot</th>
<th>Yes, limited a little</th>
<th>No, not limited at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>[  ]</td>
<td>[  ]</td>
<td>[  ]</td>
</tr>
</tbody>
</table>

   a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf
      ..........................................................  \[ 1 \] \[ 2 \] \[ 3 \]

   b. Climbing several flights of stairs
      ................................. \[ 1 \] \[ 2 \] \[ 3 \]
3. During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities, as a result of your physical health?

<table>
<thead>
<tr>
<th></th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little bit of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. <strong>Accomplished less than you would like</strong></td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>b. <strong>Were limited in the kind of work or other activities</strong></td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities, as a result of any **emotional problems** (such as feeling depressed or anxious)?

<table>
<thead>
<tr>
<th></th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little bit of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. <strong>Accomplished less than you would like</strong></td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>b. <strong>Did work or other activities less carefully than usual</strong></td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

5. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>
6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little bit of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

a. Have you felt calm and peaceful? ............
   ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

b. Did you have a lot of energy? ...............
   ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

c. Have you felt downhearted and depressed? ...............
   ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little bit of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

Thank you for completing these questions!
Dental Evaluation: Instructions to the Patient

- Dental infections can allow bacteria into the blood stream, which can infect the heart valves.

- For anyone undergoing heart valve repair/ replacement/ TAVR or Mitra-Clip, we require that they undergo a dental exam and obtain clearance within 6 months of surgery.

- Please contact your dentist’s office to be evaluated as soon as possible.

- The attached form needs to be completed by your dentist and returned back to us no later than one week prior to your scheduled surgery, or your surgery is at risk of being postponed.

- Fax clearance to: (949) 764-1493
Heart Valve Surgery Dental Evaluation

Re: ____________________________ DOB: _______________

Dear Dentist,

Our mutual patient is scheduled to undergo heart valve surgery at Hoag Hospital. To decrease the incidence of infective endocarditis we require a careful preoperative dental evaluation so that required dental treatment may be completed whenever possible before cardiac valve surgery, per American Heart Association Guidelines.

Clearance prior to valve surgery: Please exam the patient’s mouth and indicate below if there are any identifiable sources of infection in the oral cavity. The surgeons request that you not perform prophylactic teeth cleaning at this time unless it is required to clear the patient.

If dental work is required for clearance, we request these procedures be performed with appropriate antibiotic protection.

After valve surgery: We prefer that the patient does not undergo elective dental procedures (such as dental cleaning) for three months following valve surgery. Of course, urgent dental issues should be treated as needed with antibiotic coverage.


TO BE COMPLETED BY DENTIST & FAXED TO 949-764-1493 AS SOON AS POSSIBLE

On __________ I conducted a dental examination on ________________________________ (Patient’s Name)

From the dental perspective this patient is: (Please check the appropriate box).

☐ “Cleared” I saw no indication of any gingival, periodontal or endodontic infections. From an dental aspect, I see no reason to delay their heart valve surgery.

☐ “Not cleared” I saw active gingival, periodontal or endodontic infections which, in my opinion, could place the patient at increased risk for endocarditis. I recommend the following dental work be done prior to their heart valve surgery:

________________________________________________________________________________________

________________________________________________________________________________________________

_________________________________ _________________________________
Dentist’s name (Please print) Dentist signature

_________________ _________________________________
Date Phone Number

Revised 4/23/15
ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end of life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PS 1125

Patient’s Name:
MR#

[1214]

California Hospital Association
**PART 1 – POWER OF ATTORNEY FOR HEALTH CARE**

**DESIGNATION OF AGENT:**
I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: ____________________________________________

Address: _______________________________________________________________________

_____________________________________________________________________________

Telephone: _______________________________________________________________________

(home phone) (work phone) (cell/pager)

OPTIONAL: If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternate agent: ________________________________

Address: _______________________________________________________________________

_____________________________________________________________________________

Telephone: _______________________________________________________________________

(home phone) (work phone) (cell/pager)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: ____________________________

Address: _______________________________________________________________________

_____________________________________________________________________________

Telephone: _______________________________________________________________________

(home phone) (work phone) (cell/pager)

**AGENT’S AUTHORITY:**
My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____________________________________________________________________________

_____________________________________________________________________________

(Add additional sheets if needed.)
WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:
My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

(Initial here)

OR

My agent’s authority to make health care decisions for me takes effect immediately.

(Initial here)

AGENT’S OBLIGATION:
My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENT’S POSTDEATH AUTHORITY:
My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

(Add additional sheets if needed.)

NOMINATION OF CONSERVATOR:
If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.
PART 2 – INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

END OF LIFE DECISIONS:
I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life:

(Initial here)

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

Choice To Prolong Life:

(Initial here)

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN:
Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____________________________________________________________________________________________________

(Add additional sheets if needed.)

OTHER WISHES:
(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

(Add additional sheets if needed.)
PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

1. Upon my death:

I give any needed organs, tissues, or parts.  

(Initial here)

OR

I do not authorize the donation of any organs, tissues or parts.  

(Initial here)

OR

I give the following organs, tissues, or parts only: ________________________________

(Initial here)

II. If you wish to donate organs, tissues, or parts, you must complete II. and III.

My gift is for the following purposes:

Transplant  

(Initial here)  

Research

(Initial here)

Therapy  

(Initial here)  

Education

(Initial here)

III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.

Yes  

(Initial here)  

No  

(Initial here)

2. My donated tissue may be used for applications outside of the United States.

Yes  

(Initial here)  

No  

(Initial here)

3. My donated tissue may be used by for-profit tissue processors and distributors.

Yes  

(Initial here)  

No  

(Initial here)

(Health and Safety Code Section 7158.3)
**PART 4 – PRIMARY PHYSICIAN (OPTIONAL)**

I designate the following physician as my primary physician:

Name of Physician:

Telephone: __________________________________________

Address: __________________________________________

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician:

Telephone: __________________________________________

Address: __________________________________________

**PART 5 – SIGNATURE**

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

**SIGNATURE:**

Sign and date the form here:

Date: ___________________________ Time: ___________________________ AM / PM

Signature: ___________________________ (patient)

Print name: ___________________________ (patient)

Address: __________________________________________

**STATEMENT OF WITNESSES:**

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual’s identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual’s health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.
FIRST WITNESS

Name: __________________________ Telephone: __________________________

Address: ______________________________________________________________

______________________________________________________________

Date: _____________________ Time: __________________________ AM / PM

Signature: ______________________________________________________________

(witness)

Print name: ____________________________________________________________

(witness)

SECOND WITNESS

Name: __________________________ Telephone: __________________________

Address: ______________________________________________________________

______________________________________________________________

Date: _____________________ Time: __________________________ AM / PM

Signature: ______________________________________________________________

(witness)

Print name: ____________________________________________________________

(witness)

ADDITIONAL STATEMENT OF WITNESSES:

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: ________________________________ Time: __________________________ AM / PM

Signature: ______________________________________________________________

(witness)

Print name: ____________________________________________________________

(witness)
A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of the document.

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California )
County of _____________________________ )

On (date) ____________________________ before me, (name and title of the officer) ______________, personally appeared (name(s) of signer(s)) ____________________________, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature: __________________________________________________________________ [Seal]

(notary)

PART 6 – SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: ____________________________ Time: ____________________________ AM / PM

Signature: __________________________________________________________________

(patient advocate or ombudsman)

Print name: __________________________________________________________________

(patient advocate or ombudsman)

Address: ____________________________________________________________________