Greenwoods™
Dental & Surgical Centre

Phone: (204) 779-7779
Fax: (204) 594-5768
Email: info@greenwoodsdental.com

## Surgery Date with Dr. _____

**Today's Date:** _____ **Patient:** _____

**ORAL SURGERY APPOINTMENT**

**Surgery Appointment Date:** _____

**Location:** _____

**Surgery Time:** _____

**Arrival Time:** _____

- Please note that arrival time and surgery time are subject to change if the facility makes changes to the slate
- Please note if balances are due, they are required 1 week prior to your surgery, unless other arrangements have been made by your insurance. (If Applicable)
- Please make arrangements to have an escort to pick you up and take you home at the time of discharge.

***If you have any questions or concerns, please call our office at (204) 779-7779.***

Greenwoods™
Dental & Surgical Centres
Dr. D.K Mittal Dental Corporation

# Consent to Procedure, Treatment, or Investigation

1. I freely and voluntarily agree that _____ or his/her Authorised Designate and any person(s)
RESPONSIBLE PARTY
he/she appoint to assist may perform the following Procedure(s), Treatment(s), Investigation(s).

_____

_____

2. The purpose, nature, expected outcomes and potential complications of the proposed Procedure(s), Treatment(s), Investigation(s) along with the alternative(s) (where appropriate) and the consequences of not doing the proposed.

_____
PRINTED NAME OF THE RESPONSIBLE PARTY OR AUTHORIZED DESIGNATE

3. I consent to such further extended or alternative Procedure(s), Treatment(s), Investigation(s) as may be found advisable in my interest during the course of the above Procedure(s), Treatment(s), Investigation(s).
4. I acknowledge that no guarantee or assurance for a favorable outcome has been made to me.
5. I consent to the administration of anaesthetics and drugs that I may require.
6. I agree to the disposition by the facility of any substance, tissues, or parts that may be removed. Disposition may include retention for the purposes of research, evaluation, or teaching.
7. In the event that a health care provider experiences a significant exposure to my body fluids, I consent to a sample of my blood being drawn and tested for transmissible infections (Hepatitis B, Hepatitis C, Human Immunodeficiency Virus), with the understanding that the results will be made known both to myself and to the exposed individual.

I certify that I have read and fully understand the above consent to Procedure(s), Treatment(s), Investigation(s) and that the explanations therein referred to were made to me, and the form was completed prior to Procedure(s), Treatment(s), Investigation(s) being performed.

Signed at_____ hours, this_____ day of _____ year _____.

_____
PRINTED NAME OF THE PATIENT/RESIDENT/CLIENT

_____
SIGNATURE OF THE PATIENT/RESIDENT/CLIENT

_____
PRINTED NAME OF WITNESS

_____
SIGNATURE OF WITNESS

_____
PRINTED NAME OF SUBSTITUTE DECISION-MAKER (IF APPLICABLE)

_____
SIGNATURE OF SUBSTITUTE DECISION-MAKER (IF APPLICABLE)

_____
REASON FOR SUBSTITUTE DECISION-MAKER

_____
RELATIONSHIP TO THE PATIENT/RESIDNET/ CLIEN and/or AGENCY (IF APPLICABLE)

I/we have discussed the purpose, nature, expected outcomes and potential complications of the proposed Procedure(s), Treatment(s), Investigation(s) along with the alternatives (where appropriate) and consequences of not doing the proposed Procedure(s), Treatment(s), Investigation(s) with the Patient/Resident/Client or substitute Decision-Maker.

_____ _____ _____
SIGNATURE OF AUTHORIZED DESIGNATE | PRINTED NAME OF AUTHORIZED DESIGNATE | DATE (MM/DD/YYYY)

Greenwoods™
Dental & Surgical Centres

Dr. D.K Mittal Dental Corporation

# Pre-Operative Patient Instructions for IV-Conscious Sedation

***For the safe treatment of the patient, the following pre-sedation instructions must be followed very carefully.***

**Medical Form**

- A history and physical examination must be performed by your physician within 3 months of the date of your surgery. A written report of this examination and the required test must be sent to Greenwoods Dental & Surgical Centre prior to your surgery. If the information is not received in time, your surgery may be cancelled.

**Medications**

- It is important that you take your usual blood pressure and heart medications (if applicable) the morning of the surgery with a small sip of water. Diabetic patients should not take morning insulin or diabetic medications. Bring all your current medications, in their original containers, with you on the day of your surgery.

**Food and Beverages**

- DO NOT eat or drink anything after midnight the evening before your surgery.

**Personal**

- Have a bath or shower before coming to your appointment.
- Wear loose casual clothing for your appointment (e.g., short sleeve t-shirt, tank top) that will allow easy access to both arms.
- Wear comfortable flat heeled shoes.
- Do not wear any make-up.
- Remove any contacts prior to treatment is to begin.
- Remove any nail polish or artificial nails on both index fingers, so we can monitor your oxygen levels.
- Do not bring any valuables to your appointment. This includes rings, watches, jewelry, etc.
- All piercings MUST be removed prior to surgery.
- False teeth will have to be removed prior to going into the operating room.
- Greenwoods Dental & Surgical Centre assumes no responsibility for loss of personal possessions, including glasses, dentures and hearing aids.

**Smoking**

- it would be to your benefit not to smoke 3 – 4 days prior to your surgery. Refrain from smoking 10 days after surgery.

**Change in health status**

- If your general health deteriorates (e.g., cold, cough, fever) contact the dental office within 48 hours of your schedule surgery. If in doubt, please phone the office to report the change in your health status.

**Dependent Persons (Under 18 years of age)**

- All dependent persons must be accompanied by a parent or legal guardian who will be responsible to sign the necessary papers.

**Discharge**

- You MUST be accompanied by a responsible adult who must remain in the dental office throughout your appointment and DRIVE you home afterwards (NO public transit or taxi).
- You MUST arrange to have a responsible adult stay with you for 24 hours after your surgery.
- Even though you may be fully conscious, your judgments and reactions may be impaired.
- You MUST NOT drive any vehicle, operate any machinery or use any domestic appliances for 24 hours following sedation

***It is important that you understand the circumstances surrounding this treatment.***

***If you have any questions, please do not hesitate to ask them, please call our office 204-779-7779.***

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Dental & Surgical Centres

Dr. D.K Mittal Dental Corporation

# Post-Operative Patient Instructions for IV-Conscious Sedation

***For the safe treatment of the patient, the following post-sedation instructions must be followed very carefully.***

- On the day of surgery, you should rest. Do not drive an automobile, operate machinery or sign legal documents for 24 hours following a general anaesthetic. You are considered impaired.
- Should you have any bleeding, rinse your mouth with ice cold water and BITE ON THE GAUZE provided. Leave these in place over the area of bleeding all day. Some bleeding after oral surgery is usual and may last up to 24 hours. You may substitute a wet or dry tea bag if needed.
- On the day of surgery, you should have only cold fluids. (Ex: water, juice, pop, etc). Do NOT use a straw. Please note that hot liquids (EX: soup, coffee, etc) can cause extra bleeding to occur.
- The day following surgery you may eat and drink as able, but until fully healed you should gently rinse your mouth with warm saltwater solution (1/4 tsp salt mixed with 1 cup of warm water for 7-10 days) before bed and after every meal. Tooth brushing should be resumed as soon as possible.
- Swelling is normal following surgery. This usually increases for 48 hours and then slowly resolves over the following week to 10 days. Ice packs applied in the first 24 hours will help reduce the amount of swelling. If you have severe swelling which obstructs your airway, go to the nearest emergency room immediately.
- Bruising occurs in some patients. This will change color and last for approximately 2 weeks.
- Pain follows surgical procedures. Take the any medications prescribed for you as directed. It takes 30-60 minutes from the time the medication is taken until full benefit can be expected. Strong medications can produce drowsiness. Do not drive an automobile or operate machinery while taking prescribed narcotic painkillers.
- Denture should not be removed until the patient has seen his/her dentist/denturist unless extensive bleeding occurs
- Bone Chips (sharp edges of bone) may occasional be noticed. These will usually disappear within a few weeks. If they become extremely bothersome, they can be removed by the surgeon.
- Sutures used are usually ones that dissolve on their own. Don’t be alarmed if you find small threads in your mouth.
- Following surgery, you are to refrain from smoking for at least 10 days as smoking will increase the change of infection and delay healing.
- If there is communication with the sinus cavity, please refrain from blowing your nose for 3 weeks, dab it only. If you need to sneeze, open your mouth and try to let it come out. The less pressure the better. Using **Otrivin** spray in your nose twice a day will help.

***It is important that you understand the circumstances surrounding this treatment.***

***If you have any questions, please do not hesitate to ask them, please call our office 204-779-7779.***

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
*Caring for Health* | *À l'écoute de notre santé*

WRHA SURGERY PROGRAM

# PREOPERATIVE History & Physical Form

*This form must be submitted to site at least 14 days prior to surgery date. Failure to do so may result in cancellation.*

**ENSURE ALL CONTACT INFORMATION ON BOOKING CARD IS CORRECT.**

**Preoperative Testing App:**

NAME :

DATE OF BIRTH :

P.H.I.N. :

M.H.S.C. :

Please Fax to: ☐ PAC Department Facility Fax # ___-___-___ ☐ Surgeon's Office Fax # ___-___-___

Diagnosis _____

Proposed Procedure _____ Proposed Date D D M M M Y Y Y Y

| PART A – ALERTS | No N/A | Yes | Describe (e.g. reason, language, details) |
|---|---|---|---|
| **A1. Patient Requires a Proxy** | ☐ | ☐ | Name _____ Reason _____ |
| **A2. Interpreter Required** | ☐ | ☐ | Language _____ |
| **A3. Previous Difficult Airway** | ☐ | ☐ | Describe, and identify facility of event _____ |
| **A4. Known/Suspected Obstructive Sleep Apnea** | ☐ | ☐ | ☐ Clinically Suspected/Assessment Pending _____<br>☐ Diagnosed/Severity _____ CPAP Compliance: ☐ No ☐ Yes ☐ N/A |
| **A5. Adverse Reaction to Previous Anaesthetic (patient or relative)** | ☐ | ☐ | Describe _____ |
| **A6. Previous Adverse Reaction to Transfusion** | ☐ | ☐ | Describe _____ |
| **A7. Blood Borne Infections** | ☐ | | ☐ Hepatitis B Virus ☐ Hepatitis C Virus ☐ Human Immunodeficiency Virus |
| **A8. Other Alerts** | ☐ | | ☐ Methicillin-resistant Staphylococcus aureus ☐ Clostridium difficile<br>Tuberculosis (TB): ☐ Active TB ☐ Latent TB ☐ Other, Describe: _____ |
| **A9. Allergies** ☐ See attached* | ☐ | ☐ | (include type of reaction) _____ |

| PART B – HISTORY | No N/A | Yes | Describe (e.g. type, quantity, frequency) |
|---|---|---|---|
| **B1. Tobacco Use** | ☐ | ☐ | *Pack years* _____<br>*Date quit* D D M M M Y Y Y Y |
| **B2. Vaporizer/e-cigarette use** | ☐ | ☐ | _____ |
| **B3. Recreational Drugs** | ☐ | ☐ | _____ |
| **B4. Alcohol Consumption** | ☐ | ☐ | _____ |
| **B5. Previous or Current Steroid Therapy** | ☐ | ☐ | _____ |
| **B6. Date of Last Menses** | ☐ | | D D M M M Y Y Y Y |
| **B7. Pregnancy Test** | ☐ | ☐ | *If done, results:* _____ |

**B8. Medical History** (please indicate stable or acute) ☐ See attached*

_____

_____

_____

_____

_____

_____

_____

**B9. History of Present Illness**

_____

_____

_____

**B10. Surgical History** ☐ See attached*

_____

_____

_____

**B11. Medications** ☐ No ☐ Yes (Describe)

☐ Medication Reconciliation attached (check box)

☐ See attached*

_____

_____

_____

_____

_____

_____

* Do not attach extensive encounter notes

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*Caring for Health* | *À l'écoute de notre santé*

WRHA SURGERY PROGRAM

# PREOPERATIVE History & Physical Form

*This form must be submitted to site at least 14 days prior to surgery date. Failure to do so may result in cancellation.*

**ENSURE ALL CONTACT INFORMATION ON BOOKING CARD IS CORRECT.**

NAME :

DATE OF BIRTH :

P.H.I.N. :

M.H.S.C. :

## PART C – PHYSICAL (Note any active or unstable system findings)

Height _____ cm Weight _____ kg Body Mass Index (BMI) _____ Blood Pressure _____ Heart Rate _____ $SpO_2$ _____

**CHEST** (other)**:** Rhythm _____ Murmurs _____ Air Entry _____ Adventitious Sounds _____

**HEAD & NECK:** _____ Neck circumference _____ cm

**ABDOMEN:** _____ **EXTREMITIES:** _____

## PART D – REVIEW OF SYSTEMS *Please note abnormal findings below and indicate associated code number (e.g. "D3" for Respiratory)*

| | # | |
|---|---|---|
| **D1. Central Nervous System** | ⌊___⌋ | |
| **D2. Cardiovascular** | ⌊___⌋ | |
| **D3. Respiratory** | ⌊___⌋ | |
| **D4. Genitourinary** | ⌊___⌋ | |
| **D5. Haematologic & Lymphatic** | ⌊___⌋ | |
| **D6. Endocrine & Metabolic** | ⌊___⌋ | |
| **D7. Gastrointestinal** | ⌊___⌋ | |
| **D8. Neuromuscular** | ⌊___⌋ | |
| **D9. Dermatologic** | ⌊___⌋ | |
| **D10. Other** | ⌊___⌋ | |

## PART E – OPTIMIZATION

**Blood Management Service**

☐ Consult initiated

*Consider referral if major surgery and anemia, rare blood type, multiple antibodies or patient refuses blood transfusion*
*www.bestbloodmanitoba.ca 204-787-1277*

*If possible, please address with the patient any of the following applicable items to reduce the risk of postoperative complications:*

**Healthy Behaviours**

- Active lifestyle
- Healthy diet
- Reducing excessive alcohol use
- Recreational drug cessation
- Smoking cessation

**Chronic Diseases Management**

- Diabetes screening/Blood glucose control
- COPD/Asthma
- Hypercholesterolemia
- Hypertension
- Malnutrition
- Nutritional Anemias

## PART F – LABORATORY SCREENING (patients at least 16 years of age)

☐ Check if indicated test results are attached.

***A guideline based app to determine which tests are required is available at: logixmd.com/preop***

**TESTS WITHIN 6 MONTHS OF SURGERY**
are valid, provided there has been no interim change in the patient's condition.

**CLINICAL JUDGEMENT IS REQUIRED**
as additional tests may be appropriate for some patients.

**GUIDELINE DOES NOT APPLY TO**
patients undergoing cardiac surgery or cesarean section

***Chest X-rays*** *– Not recommended* for **any** surgery *except* to facilitate diagnosis of new/worsened symptoms, or if ordered by the surgeon in the work up of a malignancy.

### FOR MINOR SURGERY*

**DO NOT ORDER PREOPERATIVE TESTS**
in asymptomatic patients.

* Associated with an expected blood loss of less than 500 mL, minimal fluid shifts and is typically done on an ambulatory basis (day surgery/same day discharge)*. It includes cataract surgery; breast surgery without reconstruction; laparoscopic cholecystectomy and tubal ligation; and most cutaneous, superficial, endoscopic and arthroscopic procedures.

***‡Access the complete adult preoperative lab test guideline** – including lists of major and minor surgery, at http://www.wrha.mb.ca/extranet/eipt/EIPT-003.php*

### FOR MAJOR SURGERY** If age (years) is:

**16 - 49:** Order **CBC**. Additional tests may be indicated for comorbid diseases. Consult guideline.‡
**50+:** Order **CBC, *ECG, $Na^+$, $K^+$, $Cl^-$, $TCO_2$, CR/eGFR***

**Major Surgery: Other tests to consider**

- **Oral Corticosteroids, DM** or **BMI greater than 40**: add Hemoglobin A1C or fasting plasma glucose.
- **Malnutrition, BMI greater than 40,** or **Liver disease**: AST, ALT, Alk Phos, GGT albumin, total and direct bilirubin & INR.
- **At high risk for iron deficiency**: add serum iron TIBC and Ferritin.
- **Thyroid disease**: add TSH.

** Associated with an expected blood loss of greater than 500 mL, significant fluid shifts and typically, at least one night in hospital^. Includes laparoscopic surgery (except cholecystectomy and tubal ligation), open resection of organs, large joint replacements, mastectomy with reconstruction, and spine, thoracic, vascular, or intracranial surgery.

^ *If the surgery is typically ambulatory but the patient has a medical or social reason for overnight admission (i.e. OSA, no support at home), still consider the surgery minor in determining which lab tests to order.*

Examining Provider: _____ (SIGNATURE) _____ (PRINTED NAME AND DESIGNATION) Examination Date: ⌊D D M M M Y Y Y Y⌋

Address: _____ Phone: ⌊___-___-____⌋ Fax: ⌊___-___-____⌋

☐ It is not necessary to repeat history and physical as no significant change noted in the patient's health status since the last examination.

Examining Provider: _____ (SIGNATURE) _____ (PRINTED NAME AND DESIGNATION) Reassessment Date: ⌊D D M M M Y Y Y Y⌋

Comments: _____