Nursing Service Plan

PROVIDENCE Health & Services

Full Name:	**Today's Date:**
Address:	
Surgeon's Name:	**Surgery Date:**
Type of Surgery:	**Surgery Center:**
Name of Emergency Contact:	**Phone #:**

Surgical History: Type of surgery and approximate year:

How is your general health overall?

Do you live with pain on a regular basis?

Rate your pain 0= no pain to 10=worse pain.
1 2 3 4 5 6 7 8 9 10

How do you currently manage your pain at home?

Do you drink alcohol beverages?

If yes, amount per day/week?

Do you smoke tobacco or vape? ☐ Yes ☐ No
If yes, how many cigarettes?

Do you use recreational drugs? ☐ Yes ☐ No
Marijuana? ☐ Yes ☐ No

List allergies reaction:

Have you ever had general anesthesia? ☐YES ☐NO
Any issues after general anesthesia? ☐YES ☐NO
If yes, describe?

Patient Signature Date:

PFV Staff Signature Date:

**Services will be provided as outlined in this service plan. This plan will be amended when services and/or patient's needs change...By signing this document the patient acknowledges that he/she will comply with rapid recovery care and treatment, and that this information is accurate.

**Patient: Please answer the questions on all the pages. Nurse will verify all the information provided (fax or email form once complete).

**Answer Yes or No if you have any of the following symptoms. **

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GENERAL HEALTH HISTORY

General:

	YES	NO
Weight loss	—	
Chills		
Fevers		
Night Sweats		
Fatigue		
Headaches		
Depression		

HEENT: Head, eyes, ears, nose, & throat

	YES	NO
Blurry Vision		
Double Vision		
Hearing loss		
Sinus Infection	—	—
Dizziness		
Ringing in ears		

Cardiovascular:

	YES	NO
Chest pain		
Irregular heartbeat		
High Blood pressure		
Low Blood pressure		
Blood Clots		
Clotting disorder		
Anemia		
Palpitation		

Neurological:

	YES	NO
Difficulty swallowing		
Changes in sensation		
Seizures		
Balance issues		
Stroke		
Difficulty Speaking		

Musculoskeletal:

	YES	NO
Rheumatoid arthritis		
Osteoarthritis		
Osteoporosis		
Fractures		
Joint replacements		
Numbness		
Tingling		

Genitourinary:

	YES	NO
Kidney disease/stones		
Incontinence		
Blood in urine		
UTIs		
Urine retention		

Gastrointestinal:

	YES	NO
Changes in appetite		
Abdominal pain		
Diarrhea		
Constipation		
Vomiting Blood		
Rectal Bleeding		
Gastric bypass		
GERD		

Integumentary:

	YES	NO
Color Changes		
Rashes		
Lesions		
Masses		
Cuts, open wounds		
Ulcers		

Respiratory:

	YES	NO
Asthma		
Shortness of breath		
Chronic cough		
COPD		
Sleep Apnea		

MEDICATION LIST

1. Please list all the medications you are currently taking.
2. All medication during stay at Forest View will be administered by the nurse.

Name of Medication	Dosage	Indication

Your SAFETY is our priority!

After your surgery, you are required to call the nursing staff for assistance during:

1. Ambulation (pls. don't try to get up by yourself)
2. Toileting
3. Skin care and surgical incision (nursing staff will assist with incisional care and dressing changes per the MD instructions.

Do you have any of the following mobility devices/equipment? If yes, please bring them with you. If you don't have any of the above, please let Forest View Staff know right away.

☐**walker** ☐**cane** ☐**crutches** ☐ **shower bench** ☐ **raised toilet seat** ☐**CPAP/BiPAP**

If you have further questions, please call Forest View at 907-212-4700