UCLA Anesthesia Preoperative Evaluation Center
Medical Consultant Checklist

Dear Medical Consultant,

Type of operation Dental Surgery under Anesthesia

Surgeon Timothy Lekavich, DDS

Type of anesthesia X general anesthesia ____monitored anesthetic care
Please fax the following required information ASAP to the surgeon's office at
_____

History and Physical:
1. Completed within one month of surgery date for all patients.
2. Please use the recommended H&P form sent with this checklist.
3. Dictated and other H&P forms will be accepted if they are comprehensive, including a review of systems and physical exam. **Please put patient name and date on all forms**.
4. Please note last menstrual cycle.

EKG:
1. Must be done within six months on ***all men over 50, and women over 60***
2. Must be done for any age patient with cardiac, renal, pulmonary disease, diabetes, or hypertension.
3. All EKGs should be done within the last 6 months. If it is over 6 months, please order and send another EKG.
4. Please fax EKG tracing, with interpretation and old EKG if it is abnormal.

Pacemaker/ Defibrillator: If the patient has one, send most recent pacemaker or AICD check.

Stress Test/ Echocardiogram: Please include EKG tracings with any reports. If the patient has had cardiac problems (aortic stenosis, CAD, MI, CHF, MVP, heart surgery, angioplasty, irregular heart beat, pulmonary hypertension) send report of test results.* Please see attached guideline for non-invasive cardiac testing

CBC: If the patient had chemotherapy in last six months, history of renal failure, anemia, or bleeding tendency, please send report.

Electrolytes, BUN, Creatinine, glucose If patient has diabetes, renal failure, is on diuretics, digoxin, or steroids or has a pacemaker, please send report.

CXR: If patient had recent pneumonia, CHF, please send report.

Thank you for your cooperation!

UCLA Preoperative Evaluation Service - Suggested Guidelines for Non-Invasive Cardiac Testing before Elective Surgery

These guidelines are intended to complement current preoperative medical assessment by the patient's internist or cardiologist. The medical consultant should determine if the patient is in optimum condition and state whether additional diagnostic evaluation or medical therapy is necessary to optimize the patient. We want to identify patients who cannot increase cardiac output in response to metabolic demands after major surgery or at increased risk of cardiac complications despite optimal medical management (e.g., extensive myocardial ischemia on perfusion imaging or stress echo). The following conditions warrant further work-up as indicated:

1. **Good functional capacity (≥ 7 METS or heart rate >130 without angina or dyspnea)**
   Indicated work-up: No further cardiac work-up is needed. Current assessment by the patient's internist should confirm optimal medical management of comorbidities.
   ≥ 7 METS ≡ Vigorous-Intensity Activity:

Racewalking, jogging, or running	Mowing lawn with hand mower	Swimming laps
Singles tennis	Bicycling more than 10 mph or on steep uphill terrain	
Moving or pushing furniture	Running up 1 flight stairs while carrying ≥ 25 lbs.	

2. **Angina or Dyspnea on Exertion** with risk factor(s) for CAD or CHF + ANY ONE of the following:
   a) No diagnostic stress test (exercise or pharmacologic) within last 2 years
   b) Worse than when previously tested
   c) Induced with minimal (< 4 METS) exertion
   Recommended work-up: Non-invasive stress test including assessment of ventricular function

3. **Poor (or Cannot Assess) Exercise Tolerance** + No Stress Test within last 2 years + Intermediate**- to High-Risk** Surgery + at least one risk factor for postoperative cardiac complications*
   Recommended work-up: Non-invasive stress test including assessment of ventricular function *unless* clinical assessment can confidently exclude CAD or limited cardiac output as the cause of limited functional capacity.

4. **Previous ABNORMAL Stress Test** + Poor Exercise Tolerance
   Required: Cardiology evaluation to optimize risk reduction, discuss scope of procedure (e.g. possible less invasive treatment options) and perioperative antiplatelet therapy with the surgeon, consider risk/benefit of preoperative revascularization, and make recommendations for perioperative care.

5. **Valvular Heart Disease or Pulmonary Hypertension** (suspected or documented)
   Recommended work-up: The patient's internist or cardiologist should assess presence and severity of disease or progression since previous evaluation.

6. **Abnormal 12-lead EKG:**
   a) Compare with previous EKG's whenever possible
   b) Abnormalities include previous MI (Q waves, poor anterior R progression), myocardial ischemia (ST depression or T wave inversion), non-specific ST-T changes, LBBB, and LVH
   Recommended work-up: The patient's internist or cardiologist will determine the need for additional assessment of the presence/severity of coronary artery disease or left ventricular function. Factors to consider include the presence of chest pain or dyspnea on exertion, exercise tolerance, and clinical risk factors, as well as the results and dates of previous cardiac tests.

7. **Presence of a cardiac rhythm management device (CRMD: pacemaker or AICD)**
   Indicated work-up: The patient should be sent to the UCLA Kurlan Heart Center (310-794-1710) to assess CRMD function, determine whether a patient is CRMD-dependent for pacemaking function, and to schedule a visit immediately before surgery for device reprogramming as needed.

*** Risk factors for Cardiac Complications**
- a) Previous MI
- b) History CHF
- c) Peripheral Arterial Disease (including Stroke/TIA not due to cardiac embolus)
- d) Diabetes Mellitus
- e) Chronic Kidney Disease (Males: Cr ≥2.0; Females: Cr ≥1.7; or eGFR<45 cc/min.)
- f) Abnormal EKG (previous MI, ischemia, or possibly associated with CAD; see #6 above)

****High-risk surgery:**
Aortic surgery or lower extremity revascularization

****Intermediate-risk surgery:**
Thoracic surgery
Intracranial neurosurgery
Renal Transplantation
Major Head and Neck surgery
Significant Blood Loss or Major Fluid Shifts, pertinent:
General Surgery, GYN-Oncology, Urology, Orthopedic Surgery

UCLA Health System

HISTORY & PHYSICAL
LONG FORM / COMPREHENSIVE

(Comprehensive H&P required for all admissions ≥ 24 Hours

Date:	**Service:**					
Chief Complaint:						
History of Present Illness:						
Allergies:						
Medications:						
Past Medical History: (N/C = non-contributory)	**N/C**	**CAD**	**CVA**	**HTN**	**DM**	**Other:**
Past Surgical History: N/C ☐						
Family History: N/C ☐						
Relevant Social History:	**N/C** ☐	**ETOH**	**IVDA**	**Tobacco** ____ **Packs x** ____ **yrs**		

Review of Systems CHECK ALL APPROPRIATE BOXES

GENERAL:	☐ WNL	☐ Other
SKIN:	☐ WNL	☐ Other
ENT:	☐ WNL	☐ Other
EYES:	☐ WNL	☐ Other
CV:	☐ WNL	☐ Other
RESP:	☐ WNL	☐ Other
GI:	☐ WNL	☐ Other
GU:	☐ WNL	☐ Other
Muscl:	☐ WNL	☐ Other
Neuro:	☐ WNL	☐ Other
Hemat/Lymph:	☐ WNL	☐ Other

Examining Practitioner: **Pager #:**

Attending MD: **Pager #:**

UCLA Health System

HISTORY & PHYSICAL
LONG FORM / COMPREHENSIVE

(Comprehensive H&P required for all admissions ≥ 24 Hours

Allergic/Immuno:	☐ WNL	***Reactions to:***	☐ Drugs	☐ Food	☐ Insects	☐ Skin rashes
	☐ Trouble breathing		☐ Persistent infections		☐ HIV exposure	
Endo:	☐ WNL	☐ Diabetes	☐ Thyroid Dysfunction			
Psych:	☐ WNL	☐ Nervousness	☐ Anxiety	☐ Depression	☐ Previous psych care	☐ Hallucinations
Other:						

Physical Exam: CHECK ALL APPROPRIATE BOXES		**Vital Signs: B/P P R T**
General:	☐ WNL ☐ Other	**Height:** _____ **Weight:** _____
ENT:	☐ WNL ☐ Other	
Eyes:	☐ WNL ☐ Other	
Breasts:	☐ WNL ☐ Other	
Lungs:	☐ WNL ☐ Other	
Heart:	☐ WNL ☐ Other	
Abd:	☐ WNL ☐ Other	
Musculo-Skeletal:	☐ WNL ☐ Other	
Genitalia:	☐ WNL ☐ Other	
Neurologic:	☐ WNL ☐ Other	
Skin/wounds:	☐ WNL ☐ Other	

Labs:

Studies:

CXR:

EKG:

Impression:

Plan:

Examining Practitioner: **Pager #:**

Attending MD: **Pager #:**

UCLA Health System

ADMISSION MEDICATION HISTORY FORM

Dear Patient,
Please list all the medications that you are currently taking at home. Please include prescription medications, non-prescription medications (over-the-counter), vitamins, herbals and vaccination information if available.

Allergies:_____ _____ Height: _____ Weight: _____

Prescription Medications (Please write clearly using ink.)

☐ Not taking any medications at home.

Medication	Dose	Directions for Use (How often are you taking it? For example: once daily, twice daily)	Time/ Date of last dose	For UCLA use only Healthcare Provider Review: Continued on admit	Reconcil-iation Needed/ Done		Drug supply at home
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

Over the Counter Medications/Vitamins/Herbal Agents/Vaccines

1.						
2.						
3.						
4.						

Immunization Status:

Influenza: Last Received: _____ ☐ Unknown ☐ never
Pneumococcal: Last Received: _____ ☐ Unknown ☐ never
Tetanus: Last Received: _____ ☐ Unknown ☐ never

Pediatrics:
Immunizations Up to Date
☐ Yes ☐ No ☐ Unknown

Patient Signature: _____ Date: _____

Below is for UCLA use only:

Notes: _____

Pharmacist (Print) Name: _____ Date: _____ Time: _____

Pharmacist Signature: _____ Pager: _____

Note: PTU RN – please fax to OR pharmacy x73660

PLACE form at the front of the PROGRESS NOTE SECTION of the Medical Record