Dr. Anthony Nadolski, DDS

Section Head, Dentistry

Island Health

Dear Client or Caregiver;

Enclosed are the forms to be filled out for your hospital dental visit.

Please fill out each form carefully and have the authorizing individual sign where indicated. Please ensure that all medications and conditions are included in the health history. If you require a Public Trustee to sign the consent form, please inform our office and we will contact them directly.

These forms need to be filled out and returned as soon as possible so the booking can be completed and sent to the hospital to be included on the waitlist.

You may be contacted with an appointment required for an *anaesthesia consultation*. This is a consultation with the anaesthesiologist to determine the best way to proceed with your anaesthesia on the day of surgery. This is a separate appointment usually done over the phone unless otherwise informed.

If you or your client require on-going hospital dental treatment, it is your responsibility to have new forms filled out and sent to our office after each hospital visit in order to be placed on the waitlist again. You can find new forms on our website: dranthonynadolski.com or you can contact the booking coordinator at: vicdentalbookings@gmail.com.

Forms can be dropped off or mailed to Pacific Rim Dental at 841 Yates, Victoria, B.C., V8X 1M1 or scanned and emailed to: vicdentalbookings@gmail com. We no longer have a fax machine.

Please be aware that any dental treatment rendered in the hospital will be billed to your dental insurance plan after surgery. It is your responsibility to pay the amount that won't be covered under the insurance plan. A statement will be provided for you by our office after treatment has been completed. If you do not have dental insurance, you will be responsible for the entire cost of treatment. For any billing enquiries please email drajn@shaw.ca. Please note we no longer charge a Pre-anaesthesia work up fee.

Sincerely,

Dr. Anthony Nadolski

HOSPITAL INSTRUCTIONS

Please keep these instructions for your information

A pre-operative physical with your family doctor prior to dental surgery is not required by Island Health. If you require an anaesthetic consultation, you will be contacted.

On the day of surgery please arrive 11/2 to 2 hours prior to your surgery time to check in at Surgical Daycare at the hospital as informed by the booking office.

No solid food is to be taken after midnight preceding surgery. You may have clear fluids up until 3 hours prior to booked surgical time. Clear fluids include water, plain tea or coffee. No milk, dairy products, formula or alcoholic beverages.

Take all required prescription medications the morning of surgery except; diuretics (water pills) or unless otherwise instructed.

Please bring a list of all medications, as well as the name and phone number of the person driving you home.

Prior to coming in, please have a bath or shower.

Do not bring any valuables to the hospital.

All patients having a general anaesthetic must remain in the hospital for at least 2 hours after surgery.

Following a general anaesthetic, patients must go home accompanied by a responsible adult; someone must be with you until the next day.

No task requiring skill, co-ordination or judgment should be attempted until the next day.

If you have any medical questions, please ask your family doctor or ask the anaesthesiologist at your surgical appointment.

(You can find post operative instructions for dental extractions on our website:

Dranthonynadolski.com)

PATIENT CONTACT INFORMATION

Patient name: _____

Patient Care Card number: _____

Caregiver name (if applicable): _____

Patient/Caregiver email: _____

Patient/Caregiver phone number: _____

Patient/Caregiver billing address: _____

_____

_____

_____

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Consent for Surgical and/or Special Procedures

1. I, _____ voluntarily consent for Dr. Anthony Nadolski and the staff of the Vancouver Island Health Authority (VIHA) to carry out examinations, treatments and procedures that relate to the following operation or procedure

2. The purpose and nature of, risks and benefits of, the consequences of not having treatment, and available alternatives have been explained to me by the doctor/provider named above. I have had the opportunity to ask questions and have my questions answered. I am satisfied with these explanations and I have understood them.
3. I also consent to other investigations, treatments or procedures as may be needed and as decided by the doctor/provider named above.
4. I agree that the doctor/provider named above may use the help of other surgeons, doctors, medical residents, authorized students and hospital staff.
5. I agree that for the purpose of medical education and improvement of services that tissues and bodily fluids, devices, or implants removed during the procedure may be used for such purposes, including teaching, quality assurance, or research, as is approved by the hospital and in agreement with applicable law.

Signed: _____ this _____day of _____20___ at _____hrs.
(Patient or person legally authorized to give consent)

Print name: _____ _____
(If not patient) (Relationship to patient if not patient)

Witness to signature: _____ Print Name: _____
(Signature of Witness) (Printed Name of Witness)

This section to be completed by patients having a medical device implanted in their body as part of the procedure:

I understand that privacy legislation requires my written consent to disclose personal information to the foreign manufacturer of the medical device. This means that:

a) My name, address, date of birth, physician, operative procedure, manufacturer, model numbers, serial numbers and location of insertion will be sent to the manufacturer of that implant, either within or outside of Canada, so they may contact me in case of a problem with my device. My personal information has the potential to be accessed by government agencies under the law of the country where it is stored.

b) If I do not consent to the disclosure of my personal information to a foreign manufacturer, my present medical care and treatment will not be affected in any way.

c) I have been given an opportunity by my doctor/provider to ask further questions about the disclosure of my personal information for this purpose.

Signed: _____ this _____day of _____20___ at _____hrs.
(Patient or person legally authorized to give consent)

Print name: _____ _____
(If not patient) (Relationship to patient if not patient)

For the health and safety of healthcare providers, I understand that I will be tested for Hepatitis B&C and/or HIV if a staff member is exposed to my blood or body fluids. I understand that the results of these blood tests will be shared with the VIHA Occupational Health Nurse, the doctor and, when applicable, Public Health.

Items that do not apply can be crossed out and initialed by the patient or legal representative.

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MRN #: _____

Consent for Surgical and/or Special Procedures -Alternate Consent

Consent has been received, but unable to obtain signature because: _____

_____

Declaration by Interpreter:

I acknowledge that I have interpreted the contents of this Consent Form to the patient who told me that he/she understood the explanation and consents to the operation or procedure described on the other side of the form.

Signature of Interpreter: _____ Signed this ____day of _____20___ at ___hrs.

Print Name of Interpreter: _____.

Telephone Consent:

I have discussed the contents of this Consent Form with _____ who is the patient's_____ and he/she has given verbal consent for the procedure.

(Relationship to patient)

Signature of physician/provider: _____signed this ___day of _____, 20__ at ___ hrs.

Witness Signature: _____ Print Name: _____

(Health Professional) (Witness)

Certificate of Need for Urgent/Emergency Health Care:

Medical Opinion(s) Regarding the Need for Urgent/Emergency Surgical Procedure

I hereby certify that it is necessary to provide the following health care:_____

_____

without delay in order to save the patient's life, to prevent serious physical or mental harm, or to alleviate severe pain, and the patient is, in my opinion, incapable of giving or refusing consent, and has not previously indicated that consent would be refused. I have been unable to consult with any available substitute decision maker, within a reasonable time in the circumstances.

Signature of physician/provider: _____signed this ___day of _____, 20__ at ___ hrs.

Print name: _____
(Physician/Provider)

It is recommended, but not mandatory, that a second medical staff member of the Vancouver Island Health Authority (not a resident) signs this form. I agree with the need for the health care set out above for this patient and with the opinion on incapability. This patient's condition poses an immediate threat to his/her life or health and emergency or urgent treatment is required.

Signature of physician/provider.: _____signed this ___day of _____, 20__ at ___ hrs.

Print name: _____
(Physician/Provider)

Comments: _____

_____

Items that do not apply can be crossed out and initialed by the patient or legal representative.

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Pre-Surgical Questionnaire

IMPORTANT: In order to ensure you're fully prepared for surgery, Island Health requires that surgical patients complete the following questionnaire.

Legal Name: _____

Surgeon: _____

Birth Date: Day ____ Month ____ Year _____

Health Card Number _____

Family Doctor: _____

Height: _____ Weight: _____ ☐Female ☐Male ☐Other

To the best of your ability, please respond to the questions below. If you are unsure about specific questions, please check "unsure."				
Have you ever had ANY of the following...	**NO**	**YES**	**UNSURE**	**If YES, check all that apply, and provide details where requested**
Anesthesia				
1. Problems during past procedures involving anesthesia?				Please describe reaction:
2. Blood relative with life-threatening reaction to anesthesia?				Please describe reaction:
3. Malignant hyperthermia or life-threatening reaction to anesthesia?				Describe:
4. History of congenital syndrome?				Describe:
Sleep Apnea (pausing breathing while sleeping)				
5. Formal diagnosis of Sleep Apnea (with sleep study)				Use of CPAP machine or breathing device: ☐ Yes ☐ No
6. If you answered **NO** to question 5, please check all that applies				☐ Snore loudly - louder than talking or heard through closed doors? ☐ Do you often feel tired or fatigued, or sleepy during the day? ☐ Has anyone ever observed you stop breathing during your sleep?
Allergies and Reactions				
7. Allergic to latex?				
8. Other allergies or allergic-like reactions?				Please List:
Respiratory				
9. Been diagnosed with any breathing or respiratory conditions?				☐ Difficulty breathing at rest ☐ Asthma ☐ COPD – including Emphysema or Chronic Bronchitis ☐ Lung Cancer ☐ Pulmonary Fibrosis ☐ Cystic Fibrosis ☐ Home Oxygen _____ litres per minute ☐ Chest infection within last 6 months

Have you ever had ANY of the following_.	NO	YES	UNSURE	If YES, check al that apply, and provide details where requested
Function				
10. Difficulty with exercise/every day activity?				This is due to: ☐ Shortness of breath ☐ At rest ☐ During exercise ☐ Climbing a flight of stairs ☐ Mobility/Balance difficulties ☐ Joint and/or muscular pain ☐ Other _____ (describe)
Cardiovascular				
11. High blood pressure or taking blood pressure medication				More than 180/100 most of the time? ☐ Yes ☐ No
12. Heart trouble/issues?				☐ Heart attack _____ (When?) ☐ Angina/Chest Pressure/Heart pain ☐ Congestive heart failure ('fluid on your lungs') ☐ Heart valve problem or heart murmur ☐ Atrial fibrillation or irregular heart beat (arrythmia) ☐ Pulmonary Hypertension ☐ Peripheral or Vascular disease ☐ Congenital heart disease ☐ Treated for any of the above (including blood thinners)? ☐ Other: _____ (describe)
13. Implanted heart device (pacemaker or ICD)?				☐ ICD (Implantable Cardioverter Defibrillator) ☐ Pacemaker Last checked: _____ (date) Are you dependant on your pacemaker? ☐ Yes ☐ No
14. Open heart, heart valve or blood vessel surgery?				☐ Heart valve replacement ☐ Coronary bypass surgery ☐ Angioplasty/balloon procedure/Stents ☐ Other: _____ (describe)
Diabetes				
15. Any type of Diabetes?				☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ On insulin? ☐ Yes ☐ No
Kidney, Liver and Thyroid				
16. Do you have kidney failure?				Describe:
17. Are you on dialysis?				Describe:
18. Do you have liver disease?				Describe:

Have you ever had ANY of the following...	NO	YES	UNSURE	If YES, check all that apply, and provide details where requested
Neurological				
19. Any type of neuromuscular disorder/impairment?				☐ Stroke/TIA (Mini-stroke) ☐ Seizure disorder ☐ Cerebral Palsy ☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ ALS/Lou Gehrig's Disease ☐ Muscular Dystrophy ☐ Myasthenia Gravis ☐ Other: _____ (describe)
Musculoskeletal				
20. Any type of muscular/skeletal issues or disease?				☐ Rheumatoid arthritis ☐ Ankylosing Spondylitis ☐ Back pain, neck pain or deformity that limits movement
Gastrointestinal				
21. Any type of gastrointestinal issues or disease?				☐ Chronic heart burn or acid reflux ☐ Stomach ulcer ☐ Colitis ☐ Other: _____ (describe)
Hematological				
22. Any type of blood or clotting disorder/disease?				☐ **Taking BLOOD THINNERS** ☐ Sickle Cell anemia ☐ Hemophilia ☐ Anemia ☐ Blood clots _____ (describe) ☐ Hemachromatosis ☐ Von Willebrand's _____ (type) ☐ Other _____ (describe)
Infections				
23. Any type of chronic infection?				☐ HIV ☐ Hepatitis ☐ Other _____ (describe)
24. History of organ transplantation?				Describe:
Current Health, Lifestyle and Substance Use Screening				
25. Do you smoke (or did you smoke), consume alcohol or use recreational drugs?				☐ Current smoker _____ # cigarettes per day ☐ Past smoker _____ years ago ☐ Consume alcohol _____ # drinks per week ☐ Use recreational drugs Type: _____
26. History of chronic pain				On Opioid Therapy? ☐ Yes ☐ No
27. History of cancer?				☐ Chemotherapy ☐ Radiation Therapy ☐ In remission _____ # of years

Have you been hospitalized in the past 12 months? ☐ Yes ☐ No

Please list your previous surgeries starting with most recent		
Procedure	**Facility**	**Date**
1.		
2.		
3.		
4.		
5.		

Please select the Medical Specialists currently involved in your care		
☐ Cardiologist (Heart Specialist)	☐ Neurologist (Brain and Nervous System Specialist)	☐ Oncologist (Cancer)
☐ Respirologist (Lung Specialist)	☐ Endocrinologist (Metabolism Specialist)	
☐ Rheumatologist (Bone and Joint Specialist)	☐ Internist (General Internal Medicine Specialist)	
☐ Hematologist (Blood Disease Specialist)	☐ Geriatrician (Aging Specialist)	

Medications currently being taken (including over the counter, vitamins supplements and herbal remedies)			
Medication/Supplement	**Dose**	**Medication/Supplement**	**Dose**
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Do you have any other medical conditions you feel we should be aware of? Please describe

Form Completed By: _____ _____

Signature: _____ **Date:** _____

VANCOUVER ISLAND health authority

OR BOOKING COMMUNICATION TOOL FOR PATIENTS WITH SPECIAL NEEDS
Surgical Services South Island

Site: RJH Fax: 250 519-1521 VGH Fax: 250 727- 4193

Patient's name:		Social Age:
Diagnosis:		
Mobility impairment:	❑ Uses wheelchair	❑ Uses walker / cane
	❑ Confined to bed	❑ other
Sensory impairment:	❑ Hearing	❑ other
	❑ Vision	
	❑ Speech	
Intellectual disability	Please explain:	❑ Needle phobia
Medication and security needs:	Has the person required sedation prior to procedure in the past? ☐ Yes ☐ No Do security services need to be present? ❑Yes ❑ No	Details:
Caregiver information		
Name:		Phone number:
Relationship:		
Who is accompanying the patient to hospital?		
Name:		Relationship:
Who will sign the consent?		
Name:		Phone number:
Relationship:		
Additional comments:		