

REVIEW OF SYSTEMS (ROS)

Constitutional Symptoms (e.g., fever, weight loss) Neg or _____

Eye <input type="checkbox"/> Neg or _____	Skin/Breast <input type="checkbox"/> Neg or _____
CV <input type="checkbox"/> Neg or _____	Neuro <input type="checkbox"/> Neg or _____
RESP <input type="checkbox"/> Neg or _____	Psych <input type="checkbox"/> Neg or _____
GI <input type="checkbox"/> Neg or _____	Endo <input type="checkbox"/> Neg or _____
GU <input type="checkbox"/> Neg or _____	Hem <input type="checkbox"/> Neg or _____
MSK <input type="checkbox"/> Neg or _____	ENT <input type="checkbox"/> Neg or _____

PHYSICAL EXAMINATION

General Appearance _____

Cardiovascular _____

Lungs and Thorax _____

HEENT _____

Neck _____

Abdomen _____

Genitourinary _____

Extremities _____

Mental Status _____

Neurological _____

VITAL SIGNS

Ht _____

Wt _____

BMI _____

BP – R _____

BP – L _____

Pulse _____

RR _____

Rest Sa O₂ _____

Exer Sa O₂ _____

Temp _____

Attach copies of any recent significant studies: echo, stress test, PFT's, etc.

NOTE: This is not an order sheet. (Please use Physician Order Sheet to initiate orders)

Pager # _____	Printed Name _____	Signature _____	Date _____	Time _____
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Complete the following information if updating an H&P that was completed within the last 30 days.

I have examined this patient, reviewed the H&P, and there are:

no changes to the patient's condition since the H&P was completed.

the following updates to the H&P: _____

Signature _____	Date _____	Time _____
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Formulation of Risk Assessment and Plan for Surgery Patients

1. Surgery specific risk Low Intermediate High Revised Cardiac Risk Index Score _____

2. Beta blockers to be started now with _____ contraindicated
 to be continued as _____ not indicated

3. DVT Prophylaxis not indicated Lovenox 40 mg Subcu Daily
 covered under order set or care map Arixtra 2.5 mg Subcu Daily
 unfractionated Heparin 5000 units Subcu every 8 hours Other: _____
 unfractionated Heparin 5000 units Subcu every 12 hours

4. Antibiotic Prophylaxis _____

5. _____

6. _____

7. _____

I will follow this patient post-op for beta blocker YES NO or I designate Dr. _____ to follow for me.