

# The **Surgery Center**

at **Akron General Health & Wellness Center**

Akron Surgical Associates, LLC  
 4125 Medina Road, Suite 104, Akron, Ohio 44333  
 Phone: 330-665-8120 Fax: 330-665-8129

Date: \_\_\_\_\_

Explain any items marked \* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Reviewer: \_\_\_\_\_

Date: \_\_\_\_\_

**OUTPATIENT DEPARTMENT USE ONLY** - Refer to other applicable forms  \*Screening Assessment for Interdisciplinary Referrals

**Skin Integrity Impairment Assessment:**

If any of the following factors are noted the patient is at moderate to high risk of pressure ulcers; refer to intervention\*.

- Impaired Nutrition.**
- Activity:** Full lift, Chair bound, Bedrest > 8 hrs, OR time > 3 hrs.
- Mobility:** Restrained, immobile, assist to full turn.
- Contenance:** Incontinence.
- Skin Condition:** Fragile, open lesions.
- Impaired Circulation, Peripheral Vascular Disease.**

**Fall Risk Assessment**

(if added scores 5 or >, refer to Intervention\*):

- Altered Cerebral Function ..... = 5
  - Previous Falls ..... = 4
  - Impaired Mobility ..... = 3
  - Sensory Perceptual Impairment = 2
  - Elimination Problems ..... = 1
  - Age > 70 ..... = 1
  - Medication Effects ..... = 1
- (Sedative, Narcotic, Cardiovascular, Psychotropics)

**TOTAL SCORE:**  
 \_\_\_\_\_

T \_\_\_\_\_ P \_\_\_\_\_

R \_\_\_\_\_ BP \_\_\_\_\_

Pain (0-10) \_\_\_\_\_

Weight \_\_\_\_\_

Height \_\_\_\_\_

Have you had a sudden change in safely walking, moving or in ability to care for yourself?  Yes\*  No  
 Have you recently experienced difficulty in speaking or swallowing? .....  Yes\*  No  
 Weight loss greater than 10 pounds in the last 3 months? .....  Yes\*  No

Initials \_\_\_\_\_

Date \_\_\_\_\_

**PHYSICIAN USE ONLY**

**History Present Illness/Chief Complaint:** \_\_\_\_\_  
 \_\_\_\_\_

**Past Medical History:**  **See Other Side**

Surgical: \_\_\_\_\_  
 Medical: \_\_\_\_\_  
 Cardiac: \_\_\_\_\_  
 Respiratory: \_\_\_\_\_  
 Metabolic (Diabetes): \_\_\_\_\_  
 Other (HTN, Bleeding Disorders, etc.): \_\_\_\_\_

**Current Medications:**  **See Other Side** \_\_\_\_\_  
 \_\_\_\_\_

**Allergies:**  **See Other Side** \_\_\_\_\_

**Examination:** T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_ Pain Level (0-10) \_\_\_\_\_ Wt. \_\_\_\_\_ ht. \_\_\_\_\_  **See Above**

WNL	Comments:	WNL	Comments:
Mental Status <input type="checkbox"/>	_____	Abdomen <input type="checkbox"/>	_____
EENT <input type="checkbox"/>	_____	Ortho. <input type="checkbox"/>	_____
Heart <input type="checkbox"/>	_____	GYN/Urology <input type="checkbox"/>	_____
Lungs <input type="checkbox"/>	_____	Other <input type="checkbox"/>	_____

**Diagnosis:** \_\_\_\_\_  
 \_\_\_\_\_

**Procedure:** \_\_\_\_\_  
 \_\_\_\_\_

**Anesthesia Requested:**  Local  M.A.C.  CS  General  Regional  Block \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*This short form history and physical may be used for all outpatient services. Upon observation or inpatient admission, a detailed interim note explaining the reason for the change in status is needed.*



