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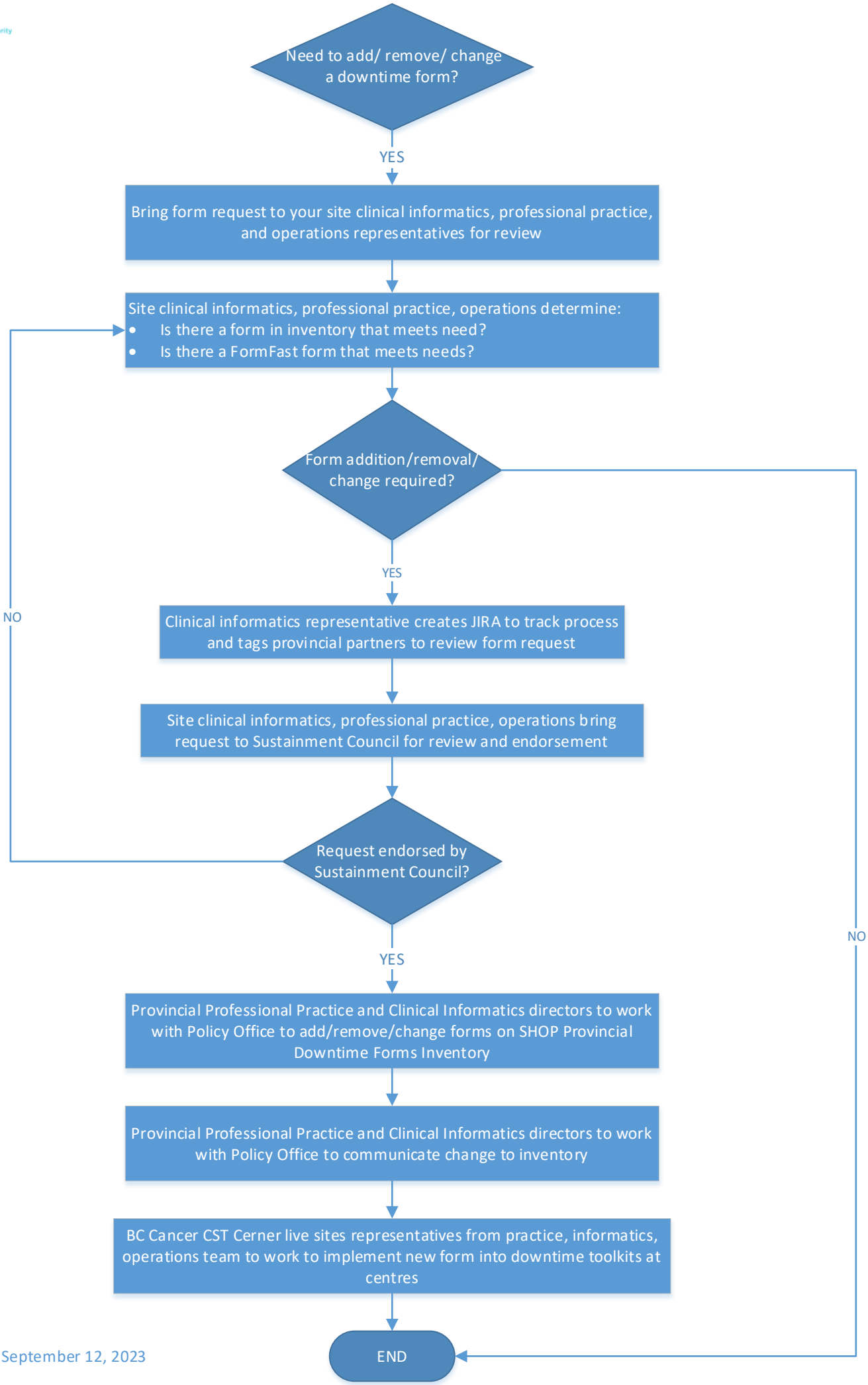
BC Cancer Provincial Downtime Form Inventory Sustainment Algorithm



Last Updated: September 12, 2023

Place Patient Label Here

INTERDISCIPLINARY SIGNATURE SHEET

Interdisciplinary
Signature Sheet

All those documenting on Patient Record must **PRINT** name, write a sample signature with status and sample initials below. Initials may then be used to identify entries.

DATE	PRINTED NAME	STATUS	SIGNATURE	INITIAL

Place Patient Label Here

INTERDISCIPLINARY SIGNATURE SHEET

Interdisciplinary
Signature Sheet

All those documenting on Patient Record must PRINT name, write a sample signature with status and sample initials below. Initials may then be used to identify entries.

DATE	PRINTED NAME	STATUS	SIGNATURE	INITIAL

Place Patient Label Here

ALLERGY/INTOLERANCE STATUS

Physician Order

IF YOU RECEIVED THIS FAX IN ERROR, CALL 604-984-5701 IMMEDIATELY

- **Must be completed by prescriber upon hospital admission. See reverse for guidelines**
- **Failure to complete this form will delay provision of drugs**
- **Fax new and revised status record to pharmacy**

DATE: TIME:		**REACTION DESCRIPTION** (See reverse for guidelines)
DRUGS	☐ NONE KNOWN	
	☐ UNABLE TO OBTAIN	
LATEX	☐ NONE KNOWN	
	☐ UNABLE TO OBTAIN	
	☐ YES	☐ **localized** ☐ **systemic**
CONTRAST MEDIA	☐ NONE KNOWN	
	☐ UNABLE TO OBTAIN	
	☐ YES	**If yes, check test if known** ☐ **CT** ☐ **IVP** ☐ **MRI** ☐ **Other**
FOOD/OTHER	☐ NONE KNOWN	
	☐ UNABLE TO OBTAIN	

MATERNITY ☐ PREGNANT ☐ BREASTFEEDING

Printed Name _____ Signature _____ College ID _____ Pager/Cell _____

NEW REACTIONS / UPDATES OCCURRING DURING ADMISSION:
Complete update below, then write **"See Updated Allergy/ Intolerance Sheet"** In Physician's Orders.

DATE & TIME	ALLERGY/ INTOLERANCE	REACTION DESCRIPTION	Signature, Printed Name, College ID	Faxed to Pharmacy

GUIDELINES FOR COMPLETING THE ALLERGY / INTOLERANCE STATUS FORM

1) It is the responsibility of the prescriber to ensure completion of this form. If the prescriber cannot be present to complete the form, a RN may take a verbal order for completion of the allergy/ intolerance status form.

2) For each allergy/intolerance noted, complete:

a) the reaction (signs and symptoms)
b) time of onset of reaction relative to drug administration (less than 24 hours, 24 to 72 hours or more than 72 hours)
c) any interventions needed, if known
d) if information on the reaction cannot be obtained, then document as "unknown". Future attempts should be made to obtain a description of the reaction.

3) If new reaction information is subsequently obtained, or the assessment is revised, the allergy/intolerance status form must be updated and faxed to pharmacy.

4) All new reactions occurring in hospital should be assessed and documented by a physician. New allergic reactions/ intolerances should be ADDED to the Allergy/ Intolerance form, dated, and the form re-faxed to Pharmacy.

Classification of reactions to latex
(See Patient Care Guidelines)

Localized: rash or localized hives following direct contact with latex

Systemic: throat constriction, bronchospasm, low blood pressure, asthma, generalized swelling, prominent rhinoconjuctivitis.

BC CANCER

Provincial Health Services Authority

IN CASE OF ALERT: Alert Label: is to be affixed sideways in this square	Addressograph

ALERT FORM

The alert section may be completed by any health care professional and is filed behind the allergy form in the patient health record.

Please check off as required:

☐ **Patient has Central Venous Access Device** Type of Device: _____	Date: Date removed:	Initials: Initials:
☐ **Patient has an implanted Electrical/ Magnetic Device** Type of Device: _____ (e.g. Pacemaker, Neurostimulator)	Date: Date removed:	Initials: Initials:
☐ **Patient requires interpreter**	Date:	Initials:
☐ **Patient previously treated with Bleomycin**	Date:	Initials:
☐ **BC Palliative Care Benefits form completed**	Date:	Initials:
☐ **Advanced Directive completed**	Date:	Initials:
☐ **DNR order completed**	Date:	Initials:
☐ **Other (**Specify) _____ _____ _____	Date:	Initials:

Place Patient Form Label Here

INTERDISCIPLINARY PROGRESS NOTES

Interdisciplinary Progress Note

DATE/TIME/DISCIPLINE FOCUS	INTERDISCIPLINARY PROGRESS NOTES ∗ Asterisk an entry if note requires follow-up response. Date and sign each entry.

Place Patient Form Label Here

INTERDISCIPLINARY PROGRESS NOTES

Interdisciplinary Progress Note

DATE/TIME/DISCIPLINE FOCUS	INTERDISCIPLINARY PROGRESS NOTES ∗ Asterisk an entry if note requires follow-up response. Date and sign each entry.

Place Patient Form Label Here

ORDERS (VCH)

Physician Order

ORDERS

Use:		Unsafe Abbreviations - do not use:		IF YOU RECEIVED THIS FAX IN ERROR, CALL 604-984-5701 IMMEDIATELY
Daily, every other day		OD, QD, QOD		
mcg		µg		COMPLETE ALLERGY/ INTOLERANCE FORM FOR ALL NEW ADMISSIONS
units		U or IU		
Use leading zero	0.25 mg	Lack of leading zero	.25 mg	
Avoid trailing zero	5 mg	Trailing zero	5.0 mg	
less than; greater than; at		Symbols	< > @	

DATE	TIME	ORDERS: DRUG - DOSE - ROUTE - FREQUENCY - DURATION SIGNATURE, PRINTED NAME, COLLEGE ID, CONTACT DETAILS

Providence HEALTH CARE

Provincial Health Services Authority
Province-wide solutions. Better health.

☐ Mount Saint Joseph Hospital ☐ St. Paul's Hospital

MEDICATION ADMINISTRATION RECORD

Scheduled Medications

(place before computer-generated MARs)

Allergies/Contraindications:

Refer to completed Caution Sheet (PHC-PH047)

For the 24 hour period from 08:00 _____ **to 07:59 on** _____ **Page:** ___ **of** ____
(Date) (Date)

08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07

Drug:
☐ new order
☐ replaces order # _____
☐ order transcribed by (initials) _____
☐ order verified by (initials) _____

Drug:
☐ new order
☐ replaces order # _____
☐ order transcribed by (initials) _____
☐ order verified by (initials) _____

Drug:
☐ new order
☐ replaces order # _____
☐ order transcribed by (initials) _____
☐ order verified by (initials) _____

Drug:
☐ new order
☐ replaces order # _____
☐ order transcribed by (initials) _____
☐ order verified by (initials) _____

Drug:
☐ new order
☐ replaces order # _____
☐ order transcribed by (initials) _____
☐ order verified by (initials) _____

Drug:
☐ new order
☐ replaces order # _____
☐ order transcribed by (initials) _____
☐ order verified by (initials) _____

08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06 07

Guidelines for Completing the Pre-Printed Medication Administration Record:

1. This Pre-printed Medication Administration Record **is not generated by pharmacy.** Ensure that this Pre-printed MAR corresponds to the Pre-Printed Order form completed by the prescriber.

2. Place Pre-Printed MAR in MAR binder in the following order:

MAR (blank, scheduled)
Pre-Printed MAR (scheduled)
Computer-generated MAR (scheduled)
Computer-generated MAR (PRN)
Pre-Printed MAR (PRN)
MAR (blank, PRN)

3. Use this form until a computer-generated MAR is sent from Pharmacy (night shift).

4. Transcribe scheduled medication orders onto this MAR from corresponding pre-printed order form.

   a) **Discontinue** all medications that have not been ordered by the prescriber on the pre-printed order form.

   b) **Blanks:** complete blanks by filling in medication name, dosage and frequency (as applicable) as indicated on pre-printed order form.

   c) **New regularly scheduled medication orders not included in pre-printed Orders**: transcribe to Medication Administration Record Scheduled (Blank) (PHC-PH205).

   d) **New PRN medication orders not included in pre-printed Orders:** may be transcribed to Pre-printed PRN MAR in spaces provided.

      i. **New order**: enter a tick to indicate it is a new order.

      ii. '**Replacement order**': enter a tick to indicate if newly written order is replacing an existing order on computer-generated MAR. From the computer-generated MAR, document the order number that this order replaces.

5. **Drug Administration Times:** Nurse will write delivery times under each order using the 24-hour clock at the top of the page as a guide.

6. **Order Transcription:** Unit Coordinator who transcribes the order writes initials where indicated.

7. **Order verification**: Nurse who verifies the order as having been accurately transcribed writes initials where indicated.

8. Per PHC guideline, for all staff "printed name, full signature, initials and discipline credentials are written on the Interdisciplinary Signature Sheet once per patient admission, and entries on all other forms are accompanied by the health care provider's full signature. Initials are used on specified forms as indicated." **This form has been approved for initials.**

Place Patient Label Here

VITAL SIGNS RECORD

Flowsheets

SEDATION SCALE
S = Sleeping (easy to rouse, NORMAL sleep)
0 = None (awake, alert)
1 = Mild (occasionally drowsy, easy to rouse)
2 = Moderate (frequently drowsy, easy to rouse)
3 = Severe (somnolent, difficult to rouse)

O2 MODALITY
NP = Nasal Prongs
SM = Simple Mask
NRB = Non Rebreathing Mask
HFFM = High Flow Face Mask
TM = Trach Mask
TP = T-Piece
FT = Face Tent

YEAR _____																					
MONTH																					
DAY																					
TIME																					
TEMPERATURE	ORAL ●	40																			40
		39																			39
	RECTAL ○	38																			38
	AXILLA X	37																			37
		36																			36
BLOOD PRESSURE	LYING L	230																			230
		220																			220
	STANDING St	210																			210
		200																			200
	SITTING S	190																			190
		180																			180
	SYSTOLIC v	170																			170
		160																			160
		150																			150
	DIASTOLIC ^	140																			140
		130																			130
		120																			120
	RADIAL ●	110																			110
		100																			100
		90																			90
	APICAL X	80																			80
		70																			70
		60																			60
	IR = Irregular Pulse	50																			50
		40																			40
BP LOCATION - RA, LA																					
RESPIRATION RATE																					
O2 SATURATION																					
O2 RA / LPM, %																					
O2 MODALITY																					
SEDATION SCALE																					
WEIGHT Kg																					
INITIALS																					
DESIGNATION																					

Place Patient Label Here

VITAL SIGNS RECORD

Flowsheets

YEAR _____

MONTH																						
DAY																						
TIME																						
TEMPERATURE	ORAL ●	40																				40
		39																				39
	RECTAL ○	38																				38
	AXILLA X	37																				37
		36																				36
BLOOD PRESSURE & PULSE	LYING L	230																				230
		220																				220
		210																				210
	STANDING St	200																				200
		190																				190
	SITTING S	180																				180
		170																				170
	SYSTOLIC V	160																				160
		150																				150
	DIASTOLIC ^	140																				140
		130																				130
		120																				120
	RADIAL ●	110																				110
		100																				100
	APICAL X	90																				90
		80																				80
	IR = Irregular Pulse	70																				70
		60																				60
		50																				50
		40																				40
BP LOCATION - RA, LA																						
RESPIRATION RATE																						
O2 SATURATION																						
O2 RA / LPM, %																						
02 MODALITY																						
SEDATION SCALE																						
WEIGHT Kg																						
INITIALS																						
DESIGNATION																						

SEDATION SCALE

- **S = Sleeping** (easy to rouse, NORMAL sleep)
- **0 = None** (awake, alert)
- **1 = Mild** (occasionally drowsy, easy to rouse)
- **2 = Moderate** (frequently drowsy, easy to rouse)
- **3 = Severe** (somnolent, difficult to rouse)

O2 MODALITY

- NP = Nasal Prongs
- SM = Simple Mask
- NRB = Non Rebreathing Mask
- HFFM = High Flow Face Mask
- TM = Trach Mask
- TP = T-Piece
- FT = Face Tent

O2 SATURATION ACTIVITY

- L = Lying
- S = Sitting
- W = Walking

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Provincial Health Services Authority

Height, Weight & BSA Record

Table 1: Height & Weight at initial referral and if BSA re-calculation required – 2 signatures required.

Date dd/mm/yy	Height(cm)	Weight(kg)	Signature 1	Signature 2	BSA(m2) (MD to calculate)

Table 2: Subsequent Weight

Date dd/mm/yy	Weight (kg)	Initials	Date dd/mm/yy	Weight (kg)	Initials	Date dd/mm/yy	Weight (kg)	Initials

Place Patient Form Label Here

ADVANCE CARE PLANNING & GOALS OF CARE DISCUSSION RECORD

ACP Goals of Care Discussion

For use by all members of the health care team

Guidelines for Use:

1. This form is for use by all members of the health care team (e.g. nurses, social workers, spiritualcare, physicians) as a written communication tool to record information relevant to discussion about advance care planning. This could include conversations about the patient's values and previously documented advance care plans, current medical condition and goals of care, including Medical Orders for Scope of Treatment (MOST) or resuscitation status.
2. Discussions with patient, family, and/or substitute decision maker are documented along with the subsequent action taken (e.g. Physician notified, or 'My Voice' guide introduced). If input is provided by someone other than the patient/SDM, indicate their name and relationship (e.g. Susan Smith, neighbour).
3. This form is placed directly before the green sleeve. The green sleeve should contain all other Advance Care Planning documents and the MOST form. **All relevant documents are to be reviewed upon admission and with a change in the patient's health status** to confirm that they reflect their most current wishes.

Conversations with patients if capable. If not, follow the hierarchy of Substitute Decision- Makers.

Date/Time & Discussed with _____ :	**Brief summary of discussion /focus/ action** *Outline the information provided to the patient/family and what was shared by patient/other (goals, understanding, fears, trade-offs, prognosis). Staff are to sign their entry, print their name & discipline.

**When patient discharged, place form in green sleeve.

Place Patient Form Label Here

ADVANCE CARE PLANNING & GOALS OF CARE DISCUSSION RECORD

ACP Goals of Care Discussion

Date/Time & Discussed with _____ :	**Brief summary of discussion /focus /action** *Outline the information provided to the patient/family and what was shared by patient/other (goals, understanding, fears, trade-offs, prognosis). Staff are to sign their entry, print their name & discipline.

**When patient discharged, place form in green sleeve.

Place Patient Form Label Here

BCC PATIENT CONSENT FOR PROCEDURE(S) AND/OR OR TREATMENT(S)

Consent Oncology

Please read this consent form carefully and feel free to ask any questions now or during your care. Your health care team is here to help you.

I understand that health professionals at the BC Cancer Agency (BCCA) will help my physician provide this procedure(s)/ treatment(s). BCCA is also an education and research institution therefore I understand that health care professionals who are in an agency approved education program may participate in my care.

My physician has fully explained to me in terms that I can understand:

- What the procedure / treatment involves
- The common foreseeable risks and potentially serious consequences of the procedure / treatment
- Specifically for treatments:
  - Why the treatment is needed
  - The likelihood that the treatment may benefit me
  - What other choices for treatment I have
  - What may happen if I do not have the treatment

It has been explained to me that during the course of the proposed procedure/treatment, unforeseen emergencies may arise that require urgent or different treatment. I authorize that such treatment be provided. For procedures requiring general or spinal anesthesia, I authorize the administration of such anesthetics or drugs that may be necessary or advisable by the anesthetist.

In signing this consent form, I agree to this procedure /method of treatment(s) or a series of treatments, and understand that I have the right to stop the procedure/treatment in whole or in part, at any time, verbally or in writing, without prejudice. I have had the chance to ask questions that were answered to my satisfaction. Specific to treatment(s), I have received information resources relating to the treatment and I have been provided information on who to contact if I have further questions.

I consent to the following recommended procedure(s) and/or treatment(s) or series of treatments.

PATIENT (OR LEGAL REPRESENTATIVE): * Witnessing is not necessary if the patient and the physician sign concurrently

_____ Dated: _____

Patient Signature — Day/Month/Year

_____ _____

Witness Signature — Witness Name (Print)

PHYSICIAN/DENTIST:

☐ I confirm I have explained the nature of the treatment(s), expected benefits, material side effects and risks, special or unusual risks, alternatives, as well as the likely consequences of not having the treatment and answered all questions:

☐ I confirm I have explained that the nature of the procedure(s), side effects and risks and answered all questions:

_____ Dated: _____

Signature & Name (print) — Day/Month/Year

BCC PATIENT CONSENT FOR PROCEDURE(S) AND/OR OR TREAMENT(S)

Consent Oncology

TO BE COMPLETED BY THE INTERPRETER:

I,_____ have interpreted consent information faithfully and accurately.
Interpreter Name (Print)

Dated: _____
Day/Month/Year

CONSENT TO TREATMENT(S)/PROCEDURE(S)/SERIES:
Procedures for Signed Patient Consent Form

BC Cancer Agency physicians and dentists will provide the patient seen at the Agency with an explanation of the anticipated nature and effects of the treatment(s)/procedure(s), including the probable consequences, the unusual risks that carry serious consequences and the alternatives, including the risk of non-treatment. A signed Consent to Treatment(s)/Procedure(s) will be obtained from the patient following full and frank disclosure and prior to the initiating any treatment or procedure. The consent includes consent to: Specified treatment(s) and/or procedure(s) or series; and emergency treatment(s)/procedure(s) if required.

The signed consent form is valid for the course(s)/series(s) of the treatments/procedures provided or sooner if the patient's condition has changed and reassessment is required or at anytime the patient and/or the MRP (Most Responsible Provider) decides that the treatment consent should be revisited. For example, a new signed Consent will be obtained for adjuvant therapy and or metastatic treatment. However, a new signed Consent is not necessary for treatment changes along the course of treatment for metastatic disease.

As a rule of thumb, if the **intent** of the treatment(s)/procedure(s) has changed, a new signed Consent should be obtained from the patient.

Signed informed consent is recommended for:

chemotherapy	radiation therapy; brachytherapy
bone marrow biopsies	lymphograms
venograms	intracavity needle aspirations/biopsies
central line insertions performed in agency clinics/units	esophageal dilations
chest tube insertions	high energy laser procedures
all procedures performed in operating rooms or procedure rooms	Any other treatment/procedure for which the MRP and/or program feels a signed/documented consent is warranted.

Procedure:

1. The form will be signed by the patient (full signature) and witnessed following disclosure by the MRP and prior to initiating any treatment/procedure. Witnessing is not necessary if the patient and MRP sign concurrently.
2. The consent form may be witnessed by any BCCA staff member or any adult family member or adult accompanying the patient.
3. The consent form will be signed and placed in the patient's chart; the patient will be provided with a copy of the consent form on request.
4. Minor alterations made to the consent form by the MRP will be initialed by the patient with date and time and witnessed by the MRP. A new consent form must be signed for any major alterations.

Place Patient Label Here

24 HOUR FLUID BALANCE RECORD (FOR 12 HOUR SHIFT)

Flowsheets

DATE: From 0700 _____ to 0700 _____

Previous 24 Hour Balance + _____

Cumulative Fluid Balance + _____

INTAKE										OUTPUT							
INTRAVENOUS							ORAL			URINE			OTHER FLUID LOSS				
													GASTRIC			TUBE (Specify)	
START TIME	STOP TIME	SOLUTION AND VOLUME	RATE	INIT.	TOTAL IV IN	TOTAL BLOOD IN	TIME	ORAL	TUBE	TIME	VOID	CATH	EMESIS	N/G	BOWEL		
SUBTOTALS																	
12 HOUR TOTAL:			**IN:**							**OUT**							
START TIME	STOP TIME	SOLUTION AND VOLUME	RATE	INIT.	TOTAL IV IN	TOTAL BLOOD IN	TIME	ORAL	TUBE	TIME	VOID	CATH	EMESIS	N/G	BOWEL		
SUBTOTALS																	
12 HOUR TOTAL:			IN:							OUT:							
24 HOUR TOTAL:			IN:			OUT:						24HOUR BALANCE + OR -					

Place Patient Label Here

24 HOUR FLUID BALANCE RECORD (FOR 12 HOUR SHIFT)

Flowsheets

DATE: From 0700 _____ **to 0700** _____

Previous 24 Hour Balance + _____

Cumulative Fluid Balance + _____

INTAKE										OUTPUT							
INTRAVENOUS							ORAL			URINE			OTHER FLUID LOSS				
													GASTRIC			TUBE (Specify)	
START TIME	STOP TIME	SOLUTION AND VOLUME	RATE	INIT.	TOTAL IV IN	TOTAL BLOOD IN	TIME	ORAL	TUBE	TIME	VOID	CATH	EMESIS	N/G	BOWEL		
SUBTOTALS																	
12 HOUR TOTAL:			**IN:**							**OUT**							
START TIME	STOP TIME	SOLUTION AND VOLUME	RATE	INIT.	TOTAL IV IN	TOTAL BLOOD IN	TIME	ORAL	TUBE	TIME	VOID	CATH	EMESIS	N/G	BOWEL		
SUBTOTALS																	

12 HOUR TOTAL:	IN:	OUT:	
24 HOUR TOTAL:	IN:	OUT:	24HOUR BALANCE + OR -

BC CANCER
Provincial Health Services Authority

BC Cancer
Ambulatory Oncology Comprehensive Intake

Addressograph

Date of Completion: _____

Form completed by: _____

Patient Summary

Chief Complaint

Mode of Arrival

- ○ Ambulatory
- ○ Bed
- ○ Carried
- ○ Car seat
- ○ Stretcher
- ○ Wheelchair
- ○ Transport
- ○ Other:

Appointment Transportation Issues

- ○ Yes
- ○ No

Reason Unable to Obtain Information

- ○ None
- ○ Clinical condition
- ○ Cognitive impairment
- ○ Language barrier
- ○ Physical impairment

Information Given By

- ☐ Patient
- ☐ Family
- ☐ Community Care/Case Manager
- ☐ Other:

Barriers to Communication

- ○ Yes
- ○ No

Answer "Yes" if the patient has language barriers, requires interpreter support, or has sensory deficits. Complete Barriers to Communication section.

Barriers to Communication

Language

Preferred Mode of Communication

- ☐ Verbal
- ☐ Sign language
- ☐ Written
- ☐ Other:

Preferred Language

- ☐ English
- ☐ French
- ☐ Cantonese
- ☐ Farsi
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Mandarin
- ☐ Portuguese
- ☐ Punjabi
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other:

Interpreter Requirements

Interpreter Language Requested

Interpretation Type

- ○ In-person
- ○ Telephone
- ○ Video
- ○ Patient declined
- ○ Other:

Reason Interpretation Declined

Interpreter

- ○ Provincial Language Services
- ○ Other language resources

Other Language Resources

- ○ Clinical Staff
- ○ Family
- ○ Friend
- ○ Volunteer
- ○ Other:

Interpreter Name and Phone Number

BC Cancer
Ambulatory Oncology Comprehensive Intake

Addressograph

Sensory Deficits

Sensory Deficits

- ☐ Blind, left eye
- ☐ Blind, right eye
- ☐ Hearing deficit, left ear
- ☐ Hearing deficit, right ear
- ☐ Nonverbal
- ☐ Paralysis, left
- ☐ Paralysis, right
- ☐ Paraplegic
- ☐ Quadriplegic
- ☐ Sensation/Touch deficit
- ☐ Speech deficit
- ☐ Uncorrected visual impairment
- ☐ Other:

Sensory Compensatory Devices

- ☐ Contacts
- ☐ Glasses
- ☐ Hearing aid L ear
- ☐ Hearing aid R ear
- ☐ Hearing aids bilateral
- ☐ Communication board or device
- ☐ Other:

Items at Bedside

- ☐ Contacts
- ☐ Glasses
- ☐ Hearing aid L ear
- ☐ Hearing aid R ear
- ☐ Hearing aids bilateral
- ☐ Communication board or device
- ☐ Other:

Measurements

Weight Measured _____ kg

Height/Length Measured _____ cm

*Document on BC Cancer Height and Weight Form per policy

Vital Signs

Temperature: _____ Pulse: _____ Blood Pressure: _____ Respiratory Rate: _____

SpaO2: _____

*Document using Nursing Notes per documentation standards

BC CANCER
Provincial Health Services Authority

BC Cancer
Ambulatory Oncology Comprehensive Intake

Addressograph

Advance Care Planning

Advance Care Plan
- ○ Yes
- ○ No
- ○ Unable to answer at this time

Patient Wishes to Receive Further Information on Advance Care Planning
- ○ Yes ○ No

Please provide information as able or if necessary, consult to another profession or department such as social work or counselling.

Type of Advance Care Plan
- ☐ Advance Care Plan
- ☐ Section 7 Standard Representation Agreement
- ☐ Section 9 Enhanced Representation Agreement
- ☐ Advance Directive
- ☐ No Cardiopulmonary Resuscitation - Medical Order
- ☐ Refusal of Blood Product
- ☐ Other:

Location of Advance Care Plan
- ○ Copy to be obtained from previous records
- ○ Copy placed on paper chart
- ○ Family to bring in copy from home
- ○ Available as scanned document in EHR
- ○ Unable to obtain copy
- ○ Other:

Additional Advance Care Planning/Goals of Care Details:

_____

_____

_____

Infectious Disease Risk Screening

Syndromic Symptom Surveillance

Does the Patient have any of the following signs or symptoms?

	Yes	No	Unable to obtain
*Suspected Viral Respiratory Infection			
*Suspected Infectious Diarrhea/Vomiting			
*Fever with H/A, Photophobia, or Alt LOC			
*Fever with Rash (e.g. Measles)			
*Fever with Parotid Swelling (e.g. Mumps)			
*Query TB (e.g. Hemoptysis)			
*Vesicular Rash (eg: Shingles,Chickenpox)			

If yes to Vesicular Rash, check details in the section below

Vesicular Rash Details
- ☐ Immunocompromised patient
- ☐ Localized shingles
- ☐ Disseminated rash
- ☐ Facial rash

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ARO History

	Yes	No	Unable to obtain
*Antibiotic Resistant Organism History			

If yes to Antibiotic Resistant Organism History, check ARO History Details section below

ARO History Details

- ☐ C. Auris
- ☐ CPO
- ☐ MRSA
- ☐ VRE
- ☐ Other/unknown

Healthcare OUTSIDE Canada in Last Year

	Yes	No	Unable to obtain
*Healthcare OUTSIDE Canada in Last Year			

If yes to receiving healthcare outside of Canada in the last year, fill in and check details below

In which facility and/or country did this foreign healthcare occur?

When did this foreign healthcare occur?

- ○ Within the last 21 days
- ○ More than 21 days ago
- ○ Unable to obtain

Have you or a household member traveled outside of Canada within the last 30 days?

- ○ No
- ○ Yes, patient
- ○ Yes, household member
- ○ Yes, patient and household member
- ○ Unable to obtain

Location of Recent Travel

- ☐ Africa
- ☐ Asia
- ☐ Australia/New Zealand
- ☐ Caribbean
- ☐ Central America
- ☐ China
- ☐ Eastern Europe
- ☐ India
- ☐ Mexico
- ☐ Middle East
- ☐ Russia
- ☐ South America
- ☐ United States
- ☐ Western Europe
- ☐ Other:

Recent Exposure to Communicable Disease

	Yes	No	Unable to obtain
*Recent Exposure to Communicable Disease			

If yes to a recent exposure to a communicable disease, check details below

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Addressograph

Communicable Disease Exposed To:

- ☐ Chickenpox or shingles
- ☐ Confirmed COVID-19 patient
- ☐ Measles
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Other:

Tuberculosis Status Description

- ☐ N/A
- ☐ Receiving treatment
- ☐ Active pulmonary TB
- ☐ Positive TB skin test
- ☐ Treated
- ☐ Unable to obtain
- ☐ Other:

Additional Comments:
_____
_____
_____

Allergies

Do you have allergies? ☐ Yes ☐ No

Allergen	Reaction (type and severity)

*Document on BC Cancer Allergy Form per policy

Medication History

Best Possible Medication History completed on BC Cancer/Excelleris Ambulatory Medication Reconciliation Form: ☐ Yes ☐ No Signature: _____

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Problems List (Medical/Procedural History)

Heart & Vascular:

☐ Heart problems, e.g. heart attacks, abnormal heart rate ☐ High blood pressure ☐ Blood clots ☐ Stroke

☐ Implanted electronic/ magnetic device, e.g. pacemaker, neurostimulator, insulin pump, defibrillator

Lung:

☐ Asthma/emphysema/COPD ☐ Tuberculosis (TB)

Kidney:

☐ Kidney disease ☐ Dialysis

Liver:

☐ Hepatitis ☐ Cirrhosis

Mental Health:

☐ Depression ☐ Anxiety ☐ Claustrophobia ☐ Other, please specify mental health concerns:

_____ _____ _____

_____

Joints & Muscles:

☐ Arthritis ☐ Connective tissue disorder, e.g. Lupus, Scleroderma ☐ Joint replacement

General:

☐ Menopause: age when your menstrual period stopped _____

Number of pregnancies: ___

Number of live births: ___

☐ Currently pregnant

Date of last menstrual period:

☐ Diabetes ☐ HIV/AIDS Medical Information

☐ Other cancer diagnosis:

_____

☐ Previous radiation therapy:

_____

☐ Past operations, please list:

_____

_____

Addressograph

☐ Other: _____

_____

Edmonton Symptom Assessment Scale

Please circle the number that best describes how you feel NOW:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
No tiredness (*Tiredness = lack of energy*)	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
No drowsiness (*Drowsiness = feeling sleepy*)	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
No nausea	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
No lack of appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible lack of appetite
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
No depression	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
No anxiety (*Anxiety = feeling nervous*)	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Best feeling of wellbeing (*Wellbeing =how you feel overall*)	0	1	2	3	4	5	6	7	8	9	10	Worst possible wellbeing
No _____ other problem (*for example, constipation*)	0	1	2	3	4	5	6	7	8	9	10	Worst possible _____

Addressograph

Tobacco Use History

Addressograph

Use:
- ◯ Never (less than 100 in lifetime)
- ◯ 4 or less cigarettes(less than 1/4 pack)/day in last 30 days
- ◯ 5-9 cigarettes(between 1/4 to 1/2 pack)/day in last 30 days
- ◯ 10 or more cigarettes(1/2 pack or more)/day in last 30 days
- ◯ Cigars or pipes daily within last 30 days
- ◯ Cigars or pipes but not daily within last 30 days
- ◯ Smoker, current status unknown
- ◯ Former smoker, quit more than 30 days ago
- ◯ Refused tobacco status screen
- ◯ Not obtained
- ◯ Other:

Type:
- ☐ Cigarettes
- ☐ Cigars
- ☐ Oral
- ☐ Pipe
- ☐ Smokeless Cigarettes
- ☐ Smokeless Spit Tobacco
- ☐ SNUS Pouches
- ☐ Other:

Tobacco Use Per Day:

Number of Years:

Total Pack Years:

Smokeless Tobacco Use:
- ☐ Never
- ☐ Smokeless tobacco user within last 30 days
- ☐ Former smokeless tobacco user, quit more than 30 days ago
- ☐ Refused tobacco status screen
- ☐ Not obtained
- ☐ Other:

Exposure to Secondhand Smoke: ◯ Yes ◯ No

Started at Age: Year(s)

Stopped at Age: Year(s)

Previous Treatment:
- ☐ None
- ☐ Counseling
- ☐ Hypnosis
- ☐ Medications
- ☐ Nicotine replacement
- ☐ Other:

Alcohol Use History

Addressograph

Type:
- ☐ Beer
- ☐ Wine
- ☐ Liquor
- ☐ Other:

Frequency:

Comment:

Average Drinks Per Day:

Date Last Used:

Binge Pattern Abuse ◯ Yes ◯ No

Started at Age: Year(s)

Stopped at Age: Year(s)

Previous Treatment:
- ☐ None
- ☐ Inpatient
- ☐ Outpatient
- ☐ Peer Support Group
- ☐ Therapeutic Program
- ☐ Other:

Substance Use History

Concerns About Substance Use in Household: ◯ Yes ◯ No

Has Drug Use Interfered with Your Work or Home Life ◯ Yes ◯ No

Previous Treatment: ◯ None ◯ Treatment center

Substance Use:
- ◯ Not assessed
- ◯ No issues identified
- ◯ Other:

Types of Substances: _____

Addressograph

Sexual Health History

Sexually Active:
☐ Yes ☐ No
Self describe Orientation: _____
Preferred Pronouns: _____
Contraceptive Use/Type: _____
Other Sexual Concerns: _____

Ethnicity

Ethnicity

☐ Black/African Descent (African, Afro-Caribbean, African Canadian descent, North African descent	☐ Latino (Latin American, Hispanic descent)
☐ East Asian – Chinese	☐ South Asian (East Indian, Pakistani, Sri Lankan, etc)
☐ East Asian – Japanese	☐ Southeast Asian - (Filipino)
☐ East Asian – Korean	☐ Southeast Asian – Other (Vietnamese, Cambodian, Malaysian, Laotian)
☐ Indigenous (First Nations, Metis, Inuit)	☐ White/European Descent (European descent NOS)
☐ Jewish	☐ Don't know
☐ Middle Eastern - Arab	☐ Prefer not to answer
☐ Middle Eastern – other (Iranian/Persian, Egyptian, Persian, Kurdish, etc)	☐ Other:

Comment:

Employment Status

Status

☐ Disability	☐ Student
☐ Employed	☐ Unemployed
☐ Income assistance	☐ Other:
☐ Retired	

Description: _____
Hazardous Equipment Operation? Yes ☐ No ☐

Addressograph

Work Hazards

- [ ] Hazardous materials
- [ ] Repetitive motion
- [ ] Heavy lifting/twisting
- [ ] Shift/Night work
- [ ] Loud noises
- [ ] Vibration
- [ ] Medical/Clinical work
- [ ] Other:

Comments: _____

Education

Highest Education Achieved: _____

Home Environment

Lives with:

- [ ] Alone
- [ ] Mother
- [ ] Children
- [ ] Paid caregiver
- [ ] Father
- [ ] Siblings
- [ ] Foster care
- [ ] Significant other
- [ ] Friend
- [ ] Spouse
- [ ] Legal guardian
- [ ] Other:

Primary Care Giver: _____

Guardian(*s) Information: _____

Sibling(s) Information: _____

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Living Situation:	Lives In:	Home Ownership:
◯ House ◯ Assisted living ◯ Apartment ◯ Group home ◯ Homeless ◯ Hospice ◯ Independent living facility ◯ Low barrier housing ◯ Residential care ◯ Shelter ◯ Supported independent living ◯ Temporary housing ◯ Transitional housing ◯ Other:	◯ Apartment ◯ Basement suite ◯ Mobile home ◯ Multi-level home ◯ Single level home ◯ Single room occupancy ◯ Other:	◯ Owns ◯ Rents ◯ Other:

Home Equipment

- ☐ Cane
- ☐ Commode
- ☐ CPAP/BiPAP
- ☐ Elevator
- ☐ Feeding Tube
- ☐ Floor to ceiling pole
- ☐ Glucose monitoring
- ☐ Grab bars
- ☐ Hospital bed
- ☐ IV therapy
- ☐ Monitoring
- ☐ Oxygen
- ☐ Prop
- ☐ Raised toilet seat
- ☐ Ramp
- ☐ Respiratory treatments
- ☐ Scooter
- ☐ Shower seat
- ☐ Suction
- ☐ Trapeze
- ☐ Ventilator
- ☐ Walker
- ☐ Wheelchair
- ☐ Other:

Special Services and Community Resources

- ☐ Adult Protective Services
- ☐ Child Protective Services
- ☐ Clergy
- ☐ Counseling
- ☐ Court order
- ☐ Discharge transportation
- ☐ Gifted program
- ☐ Housekeeping
- ☐ Restraining order
- ☐ Schooling
- ☐ Special education
- ☐ Support group
- ☐ Other:

Smoker in Household: ◯ Yes ◯ No

Feels Unsafe at Home: ◯ Yes ◯ No

Safe Place to Go: ◯ Yes ◯ No

Agency(s)/Others Notified: ◯ Yes ◯ No

Family/Friends Available to Help: ◯ Yes ◯ No

Concern for Family Members at Home: ◯ Yes ◯ No

Major Illness in Household: ◯ Yes ◯ No

Financial Concerns: ◯ Yes ◯ No

Other Risks in Environment:

- ☐ Unlocked guns
- ☐ Does not use seat belts
- ☐ Does not wear helmet
- ☐ Hazardous chemicals/paint
- ☐ High risk sports
- ☐ Pets/Animal exposure
- ☐ Pool/Lake
- ☐ Smoke/CO detectors absent
- ☐ Stairs
- ☐ No others declared
- ☐ Other:

Smoking Cessation Intervention

Have you used tobacco in the last six months?	○ Yes ○ No
Ask Advise Refer (AAR) conversation completed and smoking cessation referral offered:	○ Yes ○ No
Smoking Cessation referral accepted	○ Yes ○ No

STEADI Fall Risk Screening

Patient Portion

Patient Scores = or > than 4 on Staying Independent Checklist	○ Yes ○ No

Clinician Portion

Fell in Past Year	○ Yes ○ No
How Many Times	
Were You Injured	○ Yes ○ No
Worries About Falling	○ Yes ○ No
Feels Unsteady When Standing or Walking	○ Yes ○ No

If answer is 'Yes' to any key questions, clinician to provide patient with Stay Independent brochure

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Code Blue - ERT Documentation

Name _____

DOB _____ _____ _____
Year Month Day

Patient BC Cancer # _____
Visitor ☐ Staff ☐

PHN # _____

DATE _____ **TIME** _____ **UNIT / AREA** _____ **CODE STATUS** _____

Reason for CODE BLUE / ERT Call _____ Witnessed Event: Yes ☐ No ☐

Document in block letters

RN #1 _____ **MD #1 Lead** _____

RN #2 _____ **MD #2 Recorder** _____

RT _____

Family Member Notified: Yes ☐ No ☐ Individual _____

TIME	**Initial Vitals:** Conscious: Yes ☐ No ☐ HR _____ BP _____ RR _____ O2 Sat _____% Gluc _____ **CPR:** Yes ☐ Time _____ No ☐

Signature: ***please sign off on all documentation**

911 called: No ☐ Yes ☐ Time _____ Ambulance Arrival Time _____

Disposition: Transfer to _____ Time _____

Team Debrief: Yes ☐ No ☐ Debrief form completed: Yes ☐ No ☐

*** Yellow copy: with patient transfer (if relevant)**
*** White copy: to Nurse Leader. Leader to send original to chart, a copy to PSLS and VC Admin Assistant.**

Place Patient Label Here

MEDICATION RECONCILIATION ORDERS

Medication Reconciliation

☐ Addendum (Page _____of_____)

*List all medications the patient is currently taking, including nonprescription drugs, herbals, samples, trial drugs and medications obtained out of the Province or over the Internet.

Medication History **Verification with:** ☐ patient ☐ Facility MAR ☐ other: ☐ **Patient not taking <u>any</u> medications**	Request medical interpreter 604-675-4099 **Medication Orders**
Drug, Dose, Route, Frequency and Duration Last taken at:	☐ Give as per verified history ☐ Discontinue ☐ Change to:
Drug, Dose, Route, Frequency and Duration Last taken at:	☐ Give as per verified history ☐ Discontinue ☐ Change to:
Drug, Dose, Route, Frequency and Duration Last taken at:	☐ Give as per verified history ☐ Discontinue ☐ Change to:
Drug, Dose, Route, Frequency and Duration Last taken at:	☐ Give as per verified history ☐ Discontinue ☐ Change to:
Drug, Dose, Route, Frequency and Duration Last taken at:	☐ Give as per verified history ☐ Discontinue ☐ Change to:
Drug, Dose, Route, Frequency and Duration Last taken at:	☐ Give as per verified history ☐ Discontinue ☐ Change to:

Medication History taken by :
☐ Prescriber or

(Date and Time) (Printed Name) (Signature)

(Designation)

*****Write all new orders on Prescriber Order Forms*****

FAX ALL PAGES TO PHARMACY

Prescriber:

(Date and Time) (College ID Number)

(Printed Name) (Signature)

PLACE ORIGINAL IN ORDERS SECTION OF CHART

Place Patient Label Here

TRANSFER OF CARE FROM ACU TO ACUTE CARE/EMERGENCY

Transfer Note

Diagnosis/Reason for Transfer:

Past Medical History:

MOST Designation:

Infection Precautions: No ☐ Yes ☐ Type:

ALLERGIES:

VS: BP **HR** **RR** **T** **SpO2** **Cardiac Rhythm**

Neuro: Cognitive Concerns: Yes ☐ No ☐
Pain: Acute/Chronic Location _____
Analg: Last dose _____ Effect _____

GU: Foley _____ Reason _____
Other _____

Resp: O_2 L/Min_____ Reason _____
WOB: Normal ☐ Increased ☐

Mobility: Indep ☐ 1 PA ☐ Ceiling Lift _____
Other _____ Falls Risk No ☐ Yes ☐

CVS: ECG _____
Failed Stress Test _____
Blood Transfusion Reaction _____
Drug Reaction _____

Integ: Altered skin: Yes ☐ No ☐
Wounds _____
Dressing to be changed: _____
For reassessment by ER Doctor: Yes ☐ No ☐
Dressing:

GI:
Diet _____
Swallowing Concerns? _____
N/V _____ Diarrhea _____
Other _____

Personal Belongings (Patient name attached)
Hearing aids ☐ Glasses ☐ Dentures ☐
Personal mobility aid _____
Medications with Patient _____ Sent Home? _____
Family Present? Yes ☐ No ☐ Aware? _____

IV Access: Saline Lock _____ IVAD _____ PICC _____
Site assessment free of redness swelling _____
Insertion Date _____
Dressing due to be changed _____

Chemo: Yes ☐ No ☐
Last received _____
Cytotoxic precautions Yes ☐ No ☐
Febrile Yes ☐ No ☐ Neutrophils _____

COPIES SENT:
Doctor History & Progress ☐ Lab Results ☐
Imaging ☐ Med Rec ☐

Comments: _____

Date: _____ Time of Report: _____ Family/Patient included Yes ☐ No ☐
Name of Sending Nurse: _____ Name of Receiving Nurse: _____
Hospital/Unit Local: _____

BRITISH COLUMBIA | Ministry of Health

STANDARD OUT-PATIENT LABORATORY REQUISITION

ORDERING PRACTITIONER: ADDRESS, PHONE, MSP PRACTITIONER NUMBER

Yellow highlighted fields must be completed.

For tests indicated with a blue tick box, consult provincial guidelines and protocols (www.BCGuidelines.ca) https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

Bill to → ☐ MSP ☐ ICBC ☐ WorkSafeBC ☐ PATIENT ☐ OTHER: _____

PERSONAL HEALTH NUMBER	ICBC/WorkSafeBC NUMBER	LOCUM FOR PRACTITIONER AND MSP PRACTITIONER NUMBER:
LAST NAME OF PATIENT	FIRST NAME OF PATIENT	If this is a STAT order please provide contact telephone number:
DOB YYYY MM DD / SEX ☐ M ☐ F	Pregnant? ☐ YES ☐ NO ☐ Fasting? _____ h pc	Copy to PRACTITIONER/MSP Practitioner Number:
PRIMARY CONTACT NUMBER OF PATIENT / SECONDARY CONTACT NUMBER OF PATIENT	OTHER CONTACT NUMBER OF PATIENT	Copy to PRACTITIONER/MSP Practitioner Number:

ADDRESS OF PATIENT	CITY/TOWN	PROVINCE	POSTAL CODE

DIAGNOSIS	CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE

HEMATOLOGY

☐ Hematology profile
☐ INR
☐ Ferritin (query iron deficiency)

On Anticoagulant? ☐ Yes ☐ No
Specify: _____

HFE - Hemochromatosis (check ONE box only)
☐ Confirm diagnosis (ferritin first, ± TS, ± DNA testing)
☐ Sibling/parent is C282Y/C282Y homozygote (DNA testing)

URINE TESTS

☐ Macroscopic → microscopic if dipstick positive
☐ Macroscopic → urine culture if pyuria or nitrite present
☐ Macroscopic (dipstick) ☐ Microscopic *
☐ * Clinical information for microscopic required:
_____

CHEMISTRY

☐ Glucose – fasting (see reverse for patient instructions)
☐ Glucose – random
☐ GTT – gestational diabetes screen (50 g load, 1 hour post-load)
☐ GTT – gestational diabetes confirmation (75 g load, fasting, 1 hour & 2 hour test)
☐ GTT – non-gestational diabetes
☐ Hemoglobin A1c
☐ Albumin/creatinine ratio (ACR) - Urine

MICROBIOLOGY – LABEL ALL SPECIMENS WITH PATIENT'S FIRST & LAST NAME, DOB, PHN & SITE

ROUTINE CULTURE

On Antibiotics? ☐ Yes ☐ No Specify: _____
☐ Throat ☐ Sputum ☐ Blood ☐ Urine
☐ Superficial Wound, Site: _____
☐ Deep Wound, Site: _____
☐ Other: _____

VAGINITIS

☐ Initial (smear for BV & yeast only)
☐ Chronic/recurrent (smear, culture, trichomonas)
☐ Trichomonas testing

GROUP B STREP SCREEN (Pregnancy only)

☐ Vagino-anorectal swab ☐ Penicillin allergy

CHLAMYDIA (CT) & GONORRHEA (GC) by NAAT

Source/site: ☐ Urethra ☐ Cervix ☐ Urine ☐ Vagina ☐ Throat ☐ Rectum
Other _____

GONORRHEA (GC) CULTURE

Source/site: ☐ Cervix ☐ Urethra ☐ Throat ☐ Rectum
Other _____

STOOL SPECIMENS

History of bloody stools? ☐ Yes
☐ *C.difficile* testing ☐ Stool culture ☐ Stool ova & parasite exam
☐ Stool ova & parasite (high risk, submit 2 samples)

DERMATOPHYTES

☐ Dermatophyte culture ☐ KOH prep (direct exam)
Specimen: ☐ Skin ☐ Nail ☐ Hair
Site: _____

MYCOLOGY

☐ Yeast ☐ Fungus Site: _____

HEPATITIS SEROLOGY

☐ **Acute viral hepatitis undefined etiology**
Hepatitis A (anti-HAV IgM)
Hepatitis B (HBsAg ± anti-HBc)
Hepatitis C (anti-HCV)

☐ **Chronic viral hepatitis undefined etiology**
Hepatitis B (HBsAg; anti-HBc; anti-HBs)
Hepatitis C (anti-HCV)

Investigation of hepatitis immune status
☐ Hepatitis A (anti-HAV, total)
☐ Hepatitis B (anti-HBs)

Hepatitis marker(s)
☐ HBsAg
(For other hepatitis markers, please order specific test(s) below)

☐ **HIV Serology**
(patient has the legal right to choose not to have their name and address reported to public health = non-nominal reporting)
☐ Non-nominal reporting

OTHER TESTS – Standing Orders Include expiry & frequency

☐ ECG
☐ FIT (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program
☐ FIT No copy to Colon Screening Program

LIPIDS

✓ one box only

Note: Fasting is not required for any of the panels but clinician may specifically instruct patient to fast for 10 hours in select circumstances [e.g. history of triglycerides > 4.5 mmol/L], independent of laboratory requirements.

☐ Full Lipid Profile - Total, HDL, non-HDL, LDL cholesterol, & triglycerides (Baseline or Follow-up of complex dyslipidemia)
☐ Follow-up Lipid Profile - Total, HDL & non-HDL cholesterol only
☐ Apo B (not available with lipid profiles unless diagnosis of complex dyslipidemia is indicated)

THYROID FUNCTION

For other thyroid investigations, please order specific tests below and provide diagnosis.

☐ Monitor thyroid replacement therapy (TSH Only)
☐ Suspected Hypothyroidism (TSH first, fT4 if indicated)
☐ Suspected Hyperthyroidism (TSH first, fT4 & fT3 if indicated)

OTHER CHEMISTRY TESTS

☐ Sodium
☐ Potassium
☐ Albumin
☐ Alk phos
☐ ALT
☐ B12
☐ Bilirubin
☐ GGT
☐ T. Protein
☐ Creatinine / eGFR
☐ Calcium
☐ Creatine kinase (CK)
☐ PSA – Known or suspected prostate cancer (MSP billable)
☐ PSA screening (self-pay)
☐ Pregnancy test
☐ ß-HCG – quantitative

SIGNATURE OF PRACTITIONER	DATE SIGNED

DATE OF COLLECTION	TIME OF COLLECTION	COLLECTOR	TELEPHONE REQUISITION RECEIVED BY: (employee/date/time)

INSTRUCTIONS TO PATIENTS (See reverse)
Other Instructions:

The personal information collected on this form is collected under the authority of the *Personal Information Protection Act*. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the *Personal Information Protection Act* and when applicable the *Freedom of Information and Protection of Privacy Act* and may be used and disclosed only as provided by those Acts.

NCI Toxicity

Nervous System Disorders

Neuropathy - Sensory

- None
- Grade 1
- Grade 2
- Grade 3
- Grade 4
- Grade 5

Definition: A disorder characterized by inflammation or degeneration of the peripheral sensory nerves.
Grade 1: Asymptomatic; loss of deep tendon reflexes or paresthesia (including tingling) but not interfering with function
Grade 2: Sensory alteration or paresthesia (including tingling), interfering with function, but not interfering with ADL
Grade 3: Sensory alteration or paresthesia interfering with ADL
Grade 4: Disabling
Grade 5: Death

Neuropathy - Motor

- None
- Grade 1
- Grade 2
- Grade 3
- Grade 4
- Grade 5

Definition: A disorder characterized by inflammation or degeneration of the peripheral motor nerves.
Grade 1: Asymptomatic; clinical or diagnostic observations only; intervention not indicated
Grade 2: Moderate symptoms; limiting instrumental ADL
Grade 3: Weakness interfering with ADL; bracing or assistance to walk (e.g., cane or walker) indicated; Severe symptoms; assistive device indicated
Grade 4: Life-threatening consequences; urgent intervention indicated
Grade 5: Death

Pulmonary

Cough

- None
- Grade 1
- Grade 2
- Grade 3

Definition: A disorder characterized by sudden, often repetitive, spasmodic contraction of the thoracic cavity, resulting in violent release of air from the lungs and usually accompanied by a distinctive sound.
Grade 1: Mild symptoms; nonprescription intervention indicated
Grade 2: Moderate symptoms, medical intervention indicated; limiting instrumental ADL
Grade 3: Severe symptoms; limiting self-care ADL

Dyspnea

- None
- Grade 1
- Grade 2
- Grade 3
- Grade 4
- Grade 5

Definition: A disorder characterized by an uncomfortable sensation of difficulty breathing.
Grade 1: Shortness of breath with moderate exertion; Dyspnea on exertion, but can walk 1 flight of stairs without stopping
Grade 2: Shortness of breath with minimal exertion; limiting instrumental
ADL; Dyspnea on exertion but unable to walk 1 flight of stairs or 1 city
Grade 3: Shortness of breath at rest; limiting self-care ADL; Dyspnea with ADL
Grade 4: Life-threatening consequences; urgent intervention indicated; Dyspnea at rest; intubation/ventilator indicated
Grade 5: Death

Gastrointestinal

Anorexia

- None
- Grade 1
- Grade 2
- Grade 3
- Grade 4
- Grade 5

Definition: A disorder characterized by a loss of appetite.
Grade 1: Loss of appetite without alteration in eating habits
Grade 2: Oral intake altered without significant weight loss or malnutrition; oral nutritional supplements indicated
Grade 3: Associated with significant weight loss or malnutrition (e.g., inadequate oral caloric and/or fluid intake); tube feeding or TPN indicated
Grade 4: Life-threatening consequences; urgent intervention indicated
Grade 5: Death

Dry Mouth/Salivary Gland

- None
- Grade 1
- Grade 2
- Grade 3

Definition: A disorder characterized by reduced salivary flow in the oral cavity.
Grade 1: Symptomatic (e.g., dry or thick saliva) without significant dietary alteration; unstimulated saliva flow >0.2 ml/min
Grade 2 - Moderate symptoms; oral intake alterations (e.g., copious water, other lubricants, diet limited to purees and/or soft, moist foods); unstimulated saliva 0.1 to 0.2 ml/min
Grade 3 - Inability to adequately aliment orally; tube feeding or TPN indicated; unstimulated saliva <0.1 ml/min

Mucositis/Stomatitis

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3
- ○ Grade 4
- ○ Grade 5

Definition: A disorder characterized by inflammation of the oral mucosal.
Grade 1 - Erythema of the mucosa; Asymptomatic or mild symptoms; intervention not indicated;
Grade 2 - Patchy ulcerations of pseudomembranes; Moderate pain; not interfering with oral intake; modified diet indicated
Grade 3: Confluent ulcerations or pseudomembranes; bleeding with minor trauma; severe pain; interfering with oral intake
Grade 4:Tissue necrosis; significant spontaneous bleeding; life-threatening consequences; urgent intervention indicated
Grade 5: Death

Nausea

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3

Definition: A disorder characterized by a queasy sensation and/or the urge to vomit.
Grade 1: Loss of appetite without alteration in eating habits
Grade 2: Oral intake decreased without significant weight loss, dehydration, or malnutrition; IV fluids indicated <24 hrs
Grade 3: Inadequate oral caloric or fluid intake; IV fluids, tube feedings, TPN indicated >24 hrs, or hospitalization indicated

Vomiting

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3
- ○ Grade 4
- ○ Grade 5

Definition: A disorder characterized by the reflexive act of ejecting the contents of the stomach through the mouth.
Grade 1: 1 - 2 episodes (separated by 5 minutes) in 24 hrs
Grade 2: 3 - 5 episodes (separated by 5 minutes) in 24 hrs
Grade 3: >=6 episodes (separated by 5 minutes) in 24 hrs; tube feeding, TPN or hospitalization indicated
Grade 4: Life-threatening consequences; urgent intervention indicated
Grade 5: Death

Diarrhea

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3
- ○ Grade 4
- ○ Grade 5

Definition: A disorder characterized by frequent and watery bowel movements.
Grade 1: Increase of <4 stools per day over baseline; mild increase in ostomy output compared to baseline
Grade 2: Increase of 4 - 6 stools per day over baseline; moderate increase in ostomy output compared to baseline
Grade 3: Increase of >=7 stools per day over baseline; incontinence; hospitalization indicated; severe increase in ostomy output compared to baseline; limiting self-care ADL
Grade 4: Life-threatening consequences; urgent intervention indicated
Grade 5: Death

Constipation

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3
- ○ Grade 4
- ○ Grade 5

Definition: A disorder characterized by irregular and infrequent or difficult evacuation of the bowels.
Grade 1: Occasional or intermittent symptoms; occasional use of stool softeners, laxatives, dietary modification, or enema
Grade 2: Persistent symptoms with regular use of laxatives or enemas; limiting instrumental ADL
Grade 3: Obstipation with manual evacuation indicated; limiting self care ADL
Grade 4: Life-threatening consequences; urgent intervention indicated
Grade 5: Death

General Disorders

Chills

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3

Definition: A disorder characterized by a sensation of cold that often marks a physiologic response to sweating after a fever.
Grade 1: Mild sensation of cold; shivering; chattering of teeth
Grade 2: Moderate tremor of the entire body; narcotics indicated
Grade 3: Severe or prolonged, not responsive to narcotics

Fatigue

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3

Definition: A disorder characterized by a state of generalized weakness with a pronounced inability to summon sufficient energy to accomplish daily activities.
Grade 1:Fatigue relieved by rest
Grade 2: Fatigue not relieved by rest; limiting instrumental ADL
Grade 3: Fatigue not relieved by rest, limiting self-care ADL

Fever

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3
- ○ Grade 4
- ○ Grade 5

Definition: A disorder characterized by elevation of the body's temperature above the upper limit of normal.
Grade 1: 38.0 - 39.0 degrees C (100.4 - 102.2 degrees F)
Grade 2: >39.0 - 40.0 degrees C (102.3 - 104.0 degrees F)
Grade 3: >40.0 degrees C (>104.0 degrees F) for <=24 hrs
Grade 4: >40.0 degrees C (>104.0 degrees F) for >24 hrs
Grade 5: Death

Pain

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3

Definition: A disorder characterized by the sensation of marked discomfort, distress or agony.
Grade 1: Mild pain
Grade 2: Moderate pain; limiting instrumental ADL
Grade 3: Severe pain; limiting self care ADL

Skin

Rash: Acneiform

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3
- ○ Grade 4
- ○ Grade 5

Definition: A disorder characterized by an eruption of papules and pustules, typically appearing in face, scalp, upper chest and back.
Grade 1: Papules and/or pustules covering <10% BSA, which may or may not be associated with symptoms of pruritus or tenderness
Grade 2: Papules and/or pustules covering 10 - 30% BSA, which may or may not be associated with symptoms of pruritus or tenderness; associated with psychosocial impact; limiting instrumental ADL
Grade 3:Papules and/or pustules covering >30% BSA, which may or may not be associated with symptoms of pruritus or tenderness; limiting self care ADL; associated with local superinfection with oral antibiotics indicated
Grade 4: Papules and/or pustules covering any % BSA, which may or may not be associated with symptoms of pruritus or tenderness and are associated with extensive superinfection with IV antibiotics indicated; life-threatening consequences
Grade 5: Death

Rash: Hand Food Skin Reaction

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3

Definition: A disorder characterized by redness, marked discomfort, swelling, and tingling in the palms of the hands or the soles of the feet.
Grade 1 – Minimal skin changes or dermatitis (e.g., erythema, edema, or hyperkeratosis) without pain
Grade 2 – Skin changes (e.g., peeling, blisters, bleeding, edema, or hyperkeratosis) with pain; limiting instrumental ADL
Grade 3 – Severe skin changes (e.g., peeling, blisters, bleeding, edema, or hyperkeratosis) with pain; limiting self-care ADL

Rash: Maculo-papular

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3

Definition: A disorder characterized by the presence of macules (flat) and papules (elevated).
Also known as morbillform rash, it is one of the most common cutaneous adverse events, frequently affecting the upper trunk, spreading centripetally and associated with pruritus.
Grade 1: Macules/papules covering <10% BSA with or without symptoms (e.g., pruritus, burning, tightness)
Grade 2: Macules/papules covering 10 - 30% BSA with or without symptoms (e.g., pruritus, burning, tightness); limiting instrumental ADL
Grade 3 - Macules/papules covering >30% BSA with or without associated symptoms; limiting self care ADL

Vascular

Lymphedema

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3

Definition: A disorder characterized by excessive fluid collection in tissues that causes swelling.
Grade 1 - Trace thickening or faint discoloration
Grade 2 - Marked discoloration; leathery skin texture; papillary formation; limiting instrumental ADL
Grade 3 - Severe symptoms; limiting self-care ADL

Psychiatric

Insomnia

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3

Definition: A disorder characterized by difficulty in falling asleep and/or remaining asleep.
Grade 1: Mild difficulty falling asleep, staying asleep or waking up early
Grade 2: Moderate difficulty falling asleep, staying asleep or waking up early
Grade 3: Severe difficulty in falling asleep, staying asleep or waking up early

Ear

Tinnitus

- ○ None
- ○ Grade 1
- ○ Grade 2
- ○ Grade 3

Definition: A disorder characterized by noise in the ears, such as ringing, buzzing, roaring or clicking.
Grade 1: Mild symptoms; intervention not indicated
Grade 2: Moderate symptoms; limiting instrumental ADL
Grade 3: Severe symptoms; limiting self care ADL

Downtime Patient Facesheet

Recorded by:

Document not retained as part of legal record.

Visitor Status:	**VIP:**

Patient Demographic Information

Name: ,	**MRN:**
Preferred Name:	**Encounter:**
DOB:	**BC PHN:**
Age:	***Phone Numbers***
Gender:	**Preferred:**
Address:	**Home:**
	Mobile:
	Work:
Primary Care Provider:	**Alternate:**

Encounter Demographic Information

Registration Date:	**Admitting Provider:**
Registration Time:	**Attending Provider:**
Accident Related? Y/N	**Referring Provider:**

Insurance Information

Guarantor Relation to Patient:	
Primary Insurance Plan:	**Health Card/Claim#:**
Secondary Insurance Plan:	**Health Card/Claim#:**
Extended Insurance Plan:	**Health Card/Claim#:**
	Group/Policy#:

Additional Contacts

Emergency Contact Name: ,	**Relationship:**
Preferred Phone:	**Phone#:**
Next of Kin Name: ,	**Relationship:**
Preferred Phone:	**Phone#:**
Legal Guardian Name: ,	**Relationship:**
Preferred Phone:	**Phone#:**

DOWNTIME Registration PATIENT TRACKER

(Staff to fill out only columns that are relevant to the activity being recorded)

<AFFIX LABEL HERE>

Activity type: **Ex:-** *admission/discharge/transfer/LOA/service change/provider change/Encounter Type change*	**Transaction Date and Time**	**Encounter/Visit Number**	**Encounter Type**	**Medical Service**	**Reason for Visit**	**Admit Category; Admit Source; Arrival by Ambulance**	**Attending Provider**	**Location (Unit/Clinic/Dept) Transfers in/out**	**LOA (Reason; Estimated return date)**	**Discharge (Disposition; Discharged to facility)**	**Recorded by**

DOWNTIME REGISTRATION/ADT ACTIVITY LOG

Unit/Department:

(Staff to fill out only columns that are relevant to the activity being recorded)

Activity type: Ex:-*admission/ discharge/ transfer/ Encounter changes etc.*	**Transaction Date and Time**	**PHN**	**MRN**	**Encounter/visit Number**	**Last name**	**First name**	**Middle name**	**Gender**	**DOB dd-mmm-yyyy Include 'Birth Time' for Newborns**	**AttendingProvider**	**Admitting Provider**	**Medical Service**	**Room/Bed**	**Recorded by**

Infectious Disease Risk Screening

Syndromic Symptom Surveillance

Does the Patient have any of the following signs or symptoms?

	Yes	No	Unable to obtain
*Suspected Viral Respiratory Infection			
*Suspected Infectious Diarrhea/Vomiting			
*Fever with H/A, Photophobia, or Alt LOC			
*Fever with Rash (e.g. Measles)			
*Fever with Parotid Swelling (e.g. Mumps)			
*Query TB (e.g. Hemoptysis)			
*Vesicular Rash (eg: Shingles,Chickenpox)			

If yes to Vesicular Rash, check details in the section below

Vesicular Rash Details

- ☐ Immunocompromised patient
- ☐ Localized shingles
- ☐ Disseminated rash
- ☐ Facial rash

ARO History

	Yes	No	Unable to obtain
*Antibiotic Resistant Organism History			

If yes to Antibiotic Resistant Organism History, check ARO History Details section below

ARO History Details

- ☐ C. Auris
- ☐ CPO
- ☐ MRSA
- ☐ VRE
- ☐ Other/unknown

Healthcare OUTSIDE Canada in Last Year

	Yes	No	Unable to obtain
*Healthcare OUTSIDE Canada in Last Year			

If yes to receiving healthcare outside of Canada in the last year, fill in and check details below

In which facility and/or country did this foreign healthcare occur?

When did this foreign healthcare occur?

- ○ Within the last 21 days
- ○ More than 21 days ago
- ○ Unable to obtain

Have you or a household member traveled outside of Canada within the last 30 days?

- ○ No
- ○ Yes, patient
- ○ Yes, household member
- ○ Yes, patient and household member
- ○ Unable to obtain

Location of Recent Travel

- ☐ Africa
- ☐ Asia
- ☐ Australia/New Zealand
- ☐ Caribbean
- ☐ Central America
- ☐ China
- ☐ Eastern Europe
- ☐ India
- ☐ Mexico
- ☐ Middle East
- ☐ Russia
- ☐ South America
- ☐ United States
- ☐ Western Europe
- ☐ Other:

Recent Exposure to Communicable Disease

	Yes	No	Unable to obtain
*Recent Exposure to Communicable Disease			

If yes to a recent exposure to a communicable disease, check details below

Communicable Disease Exposed To:

- ☐ Chickenpox or shingles
- ☐ Confirmed COVID-19 patient
- ☐ Measles
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Other:

Tuberculosis Status Description

- ☐ N/A
- ☐ Receiving treatment
- ☐ Active pulmonary TB
- ☐ Positive TB skin test
- ☐ Treated
- ☐ Unable to obtain
- ☐ Other:

Additional Comments:

_____

_____

_____

_____

Place Patient Label Here

PERIPHERAL INTRAVENOUS ACCESS AND SUBCUTANEOUS FLOWSHEET

Flowsheets

Use this legend unless another legend is indicated: NA = Not applicable ✓ = Assessed/completed PN = See Progress Notes

Month (MMM): _____	Date (dd)											
Year (yyyy): _____	Time											
Peripheral IV	Inserted (number of attempts)											
Date inserted:	Site assessed no redness/swelling/pain/discharge											
_____	Tubing changed											
Site: _____	Converted to saline lock											
Size: _____	Saline lock flushed (min q 12 hours)											
	IV cannula removed intact											
Peripheral IV	Inserted (number of attempts)											
Date inserted:	Site assessed no redness/swelling/pain/discharge											
_____	Tubing changed											
Site: _____	Converted to saline lock											
Size: _____	Saline lock flushed (min q 12 hours)											
	IV cannula removed intact											
Peripheral IV	Inserted (number of attempts)											
Date inserted:	Site assessed no redness/swelling/pain/discharge											
_____	Tubing changed											
Site: _____	Converted to saline lock											
Size: _____	Saline lock flushed (min q 12 hours)											
	IV cannula removed intact											
SC (site changed q 7 days and prn)	Inserted											
Date inserted:	Site assessed no redness/swelling/pain/discharge											
_____	Tubing changed											
Site: _____	Cannula removed intact											
SC (site changed q 7 days and prn)	Inserted											
Date inserted:	Site assessed no redness/swelling/pain/discharge											
_____	Tubing changed											
Site: _____	Cannula removed intact											
SC (site changed q 7 days and prn)	Inserted											
Date inserted:	Site assessed no redness/swelling/pain/discharge											
_____	Tubing changed											
Site: _____	Cannula removed intact											
	Initials											

PERIPHERAL INTRAVENOUS ACCESS AND SUBCUTANEOUS FLOWSHEET

Flowsheets

Place Patient Label Here

Use this legend unless another legend is indicated: NA = Not applicable ✓ = Assessed/completed PN = See Progress Notes

Month (MMM): _____	Date (dd)											
Year (yyyy): _____	Time											
Peripheral IV Date inserted: _____ Site: _____ Size: _____	Inserted (number of attempts)											
	Site assessed no redness/swelling/pain/discharge											
	Tubing changed											
	Converted to saline lock											
	Saline lock flushed (min q 12 hours)											
	IV cannula removed intact											
Peripheral IV Date inserted: _____ Site: _____ Size: _____	Inserted (number of attempts)											
	Site assessed no redness/swelling/pain/discharge											
	Tubing changed											
	Converted to saline lock											
	Saline lock flushed (min q 12 hours)											
	IV cannula removed intact											
Peripheral IV Date inserted: _____ Site: _____ Size: _____	Inserted (number of attempts)											
	Site assessed no redness/swelling/pain/discharge											
	Tubing changed											
	Converted to saline lock											
	Saline lock flushed (min q 12 hours)											
	IV cannula removed intact											
SC (site changed q 7 days and prn) Date inserted: _____ Site: _____	Inserted											
	Site assessed no redness/swelling/pain/discharge											
	Tubing changed											
	Cannula removed intact											
SC (site changed q 7 days and prn) Date inserted: _____ Site: _____	Inserted											
	Site assessed no redness/swelling/pain/discharge											
	Tubing changed											
	Cannula removed intact											
SC (site changed q 7 days and prn) Date inserted: _____ Site: _____	Inserted											
	Site assessed no redness/swelling/pain/discharge											
	Tubing changed											
	Cannula removed intact											
	Initials											

Place Patient Form Label Here

BCC CONSENT FOR ADMINISTRATION OF BLOOD AND BLOOD PRODUCTS

Consent Blood Products

Re: _____
(Print Name of Patient)

1. My health care provider, (printed name) _____ has told me that during my treatment it may be necessary to receive administration (transfusion, infusion or injection) of blood and/or blood products (blood, blood components or other blood products) such as red blood cells, plasma, cryoprecipitate, factor concentrate, platelets, albumin or immunoglobulins (IM or IV).
2. My health care provider has also told me about the risks of receiving a transfusion from volunteer donors. I understand that risks exist even though the blood and/or blood products have been tested. I understand that in most cases the risks are small, however in some cases serious injury and/or death may result.
3. My health care provider has discussed with me autologous blood donation and other suitable treatments. I have been told that even if my own blood is used, it may still be necessary to give me other blood and/or blood products.

I have been given information on blood and/or blood products for transfusion and the chance to ask questions about the benefits and risks of blood and/or blood products for transfusion. My health care provider has answered my questions to my satisfaction.

I consent to the transfusion of blood and/or blood products if it becomes necessary during the course of my treatment.
From: _____ (date) To: _____ (date)
(Dates to be completed by Physician)

EXCEPTIONS TO CONSENT: This patient has indicated special instructions for the transfusion of blood products:

_____ _____
(Patient's Initials)

Signature (Patient or Substitute Decision Maker ∗) _____ Printed name (If Substitute Decision Maker) _____

Date _____

Signature of Prescriber _____ Printed name _____

Signature Witness (when MD not present at time of signing) _____ Printed Name of Witness _____

OR

We certify, due to the potentially urgent need for transfusion, the inability to obtain informed consent and the lack of advance directives indicating refusal of blood/blood products, we are unable to obtain informed consent prior to transfusion therapy.

Name of Physician	Signature of Physician	Date

Name of Physician	Signature of Physician	Date

*** Possible Substitute Decision Makers include:**

- A Committee of the Person, as appointed by a Court Order
- A Representative as appointed by a "Standard" Representation Agreement (restrictions apply) & defined by the "Representation Agreement Act".
- A Representative as appointed by an "Enhanced" Representation Agreement & defined by the "Representation Agreement Act".
- A "Temporary Substitute Decision Maker" [*Appointment of a Temporary Substitute Decision Maker]* form must be completed OR a TSDM referral made to the office of the Public Guardian & Trustee

This form will remain valid only for one year from date of signature and will require renewal thereafter.
Please verify date of signature.

Place Patient Form Label Here

BCC REFUSAL TO CONSENT TO BLOOD AND BLOOD PRODUCTS

Consent Refusal

This form will remain valid for the duration of this treatment course, unless revoked.

Patient Name: _____ Date of Birth: _____
(Please Print)

☐ blood products
Blood products are defined as: blood, blood components or other blood products.
Examples are red blood cells, plasma, platelets, cryoprecipitate and all human protein products, albumin, immunoglobulins (Intramuscular [IM] or Intravenous [IV]) and factor concentrates (does not include recombinant Factor VIII, recombinant Factor IX and recombinant Factor VIIa).

☐ other treatment - specify: _____

1. Dr._____ and I have discussed the risks of not receiving the above treatment.
2. I have been given information about a transfusion and was given the opportunity to ask questions and all my questions have been adequately answered. I fully understand what I have been told and what has been discussed.
3. My doctor and I have discussed the possibility of using other treatment modalities. I understand the benefits and risks of alternate treatments.
4. I have the right to change my mind at any time regarding this refusal. However, I understand there may be circumstances where it would be impossible to communicate the cancellation of this refusal such as, while unconscious.

I acknowledge that I am 19 years of age or older and am legally capable to waive these legal rights.

Dated this _____ day of _____ , 20 _____
(Month) (Year)

Name _____ Signature _____
(Please Print)

☐ Patient ☐ Parent/Guardian (Infant Act) ☐ Representative/Committee ☐ TSDM (Guardian Act)

Witness _____
(Name & Title, Please Print)

Dated this _____ day of _____ , 20 _____
(Month) (Year)

Physician Name _____ Signature _____
(Please Print)

EPICC Screening Tool

Revision: 2022 08 25

Contents

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Screening Tool Frequency and order

Screening tool & Frequency	Initial Screen	1-to-4 weeks repeat screen	At / after 30 days	At / after 60 days
ESAS-r	X	X	X	X
Canadian Problem Checklist	X		X	X
Nutrition Screening Tool	X		X	X
Advanced Care Planning	X			X

ESAS-r

Commentary: The ESAS-r is the Edmonton Symptom Assessment System, revised. It is a national standard for assessing key symptom in cancer care. Based on EPICC patient data, sleep and constipation have been added to the ESAS-r, using research-tested wording.

Please select the number that best describes how you feel NOW:												
	0	1	2	3	4	5	6	7	8	9	10	
No pain												Worst possible pain
No tiredness (tiredness = lack of energy)												Worst possible tiredness
No drowsiness (drowsiness = feeling sleepy)												Worst possible drowsiness
No nausea												Worst possible nausea
No lack of appetite (0 = full appetite, 10 = complete loss)												Worst possible lack of appetite
No shortness of breath												Worst possible shortness of breath
No depression (= feeling sad)												Worst possible depression
No anxiety (anxiety = feeling nervous)												Worst possible anxiety
Best feeling of wellbeing (wellbeing = how you feel overall)												Worst possible wellbeing
Best sleep (in last 24 hours)												Worst possible sleep
No constipation												Worst possible constipation
No _____ other problem (for example, diarrhea)												Worst possible other problem

CPC (Canadian Problem Checklist)

Commentary: Items in the CPC are adapted based on local needs and available services. Several of these items produce alerts for specific supportive cancer care services and pharmacy check-ins.

Please check all of the following items that have been of concern or a problem for you in the past week including today:		
Emotional ☐ Fears / Worries ☐ Sadness ☐ Frustration / Anger ☐ Changes in appearance ☐ Intimacy / Sexuality ☐ Coping ☐ Changes in a sense of self ☐ Loss of interest in everyday things	**Informational** ☐ Understanding my illness / treatment ☐ Talking with my health care team ☐ Making treatment decisions ☐ Knowing about available resources ☐ Quitting smoking ☐ Taking Medications ☐ I have considered suicide ☐ I want information on medical assistance in dying (MAiD)	**Practical** ☐ Returning to work / school ☐ Affording costs or loss of income ☐ Getting to & from appointments ☐ Where to stay during treatment ☐ Drug costs ☐ Child / family / elder care
Spiritual ☐ Meaning / purpose of life ☐ Faith	**Social / Family** ☐ Feeling a burden to others ☐ Worry about family / friends ☐ Feeling alone ☐ Relationship difficulties	**Physical** ☐ Concentration / Memory ☐ Diarrhea ☐ Swallowing ☐ Communication difficulties ☐ Falling / Loss of balance ☐ Tingling / numbness

MST (Malnutrition Screening Tool)

Commentary: This is a validated, internationally used tool.

1. Have you lost weight recently without trying?

- ☐ No [will take person to question 2]
- ☐ Unsure [will take person to question 2]
- ☐ Yes [if yes, the following sub-question appears]

  If YES, how much weight have you lost?

  - ☐ 2 to 13 lbs / 1 to 6 kg
  - ☐ 14 to 23 lbs / 7 to 10 kg
  - ☐ 24 to 33 lbs / 11 to 15 kg
  - ☐ More than 33 lbs / 15 kg
  - ☐ Unsure

2. Have you been eating poorly because of a decreased appetite?

- ☐ No
- ☐ Yes

Advance Care Planning

Commentary: It is important to support patients in making advance care plans before their health situation becomes critical (that is, not during symptom crises or near end-of-life). These questions provide a way for patients and health care providers talk about advance care planning regularly and ensure our documentation is up-to-date.

Creating your personalized health care plan

Advance care planning is when you think about what matters to you, what a good day looks like, how your personal beliefs and wishes fit into your future healthcare and personal care, and then sharing your wishes and preferences with others. It also means deciding who will speak for you if you cannot speak for yourself. Your BC Cancer health care team can help you start or update your planning documents at any time.

Regarding your personalized health care plan, select all that apply:

1. I have an advance care plan
2. I have named a substitute decision maker / spokesperson if I cannot speak for myself
3. I'd like to talk with someone about advanced care planning

[If either 1 or 2 is selected, a popup appears: You have indicated either that you have an advance care plan or have named a substitute decision maker. Please consider if the documents and contact information are up to date, and sharing a copy with your BC Cancer care team and your family doctor*]*

BC CANCER
Provincial Health Services Authority

PET/CT REQUISITION - Kelowna

Functional Imaging – Kelowna
PET Reception: (250)861-6456
PET Fax: (250)861-6459

Current Date: _____
Referring Physician: _____
Phone: _____
Fax: _____

For Department use only

Scan Date:_____Time: _____
Indication #:_____ 1A 1B 2 3
Details: _____
Routine H/N TB Brain ToH Arms: Up Down
Other: _____
Date: _____ PET Dr. Initial: _____

Clinical Trial Information (if applicable)
Clinical Trial Name: _____
Radiotracer Requested: _____
Contact Person: _____
Phone Number: _____

Patient Information **Important:** **Height** _____ **Weight** _____ (kg / lb)
Name: _____ Preferred Name:_____
Surname First Middle
Date of Birth: D_____ M_____ Y_____ PHN: _____ Sex: Male / Female
Home Address: _____
Home Phone: ( ) _____ Work: ( ) _____ Mobile: ( ) _____
Temporary Address: _____ Temporary Phone:( ) _____
Family Physician: _____ Phone: ( ) _____
Patient mobility: ambulatory / wheelchair / stretcher

Diagnosis/Pertinent History
(include recent surgery, chemotherapy, radiotherapy):

Specific Indication for PET/CT Request

Essential Information

			Additional Information
Does patient require an interpreter?	Y ☐	N ☐	**Language:** _____
Does patient have any drug allergies?	Y ☐	N ☐	_____
Does patient have IV contrast allergies?	Y ☐	N ☐	_____
CT scan within 3 months?	Y ☐	N ☐	**Date:** _____
MRI scan within 3 months?	Y ☐	N ☐	**Date:** _____
Nuclear Med scan within 3 months?	Y ☐	N ☐	**Date:** _____
Previous PET or PET/CT scan?	Y ☐	N ☐	**Location/date:** _____

Doctor's Signature: _____ **MSP No**: _____

Additional Copies of Report to: _____

Provincial Health Services Authority

PET/CT REQUISITION - Vancouver

Functional Imaging – Vancouver
PET Reception: (604)707-5951
PET Fax: (604)877-6245

Current Date: _____
Referring Physician: _____
Phone: _____
Fax: _____

For Department use only

Scan Date:_____Time:_____

Indication #:_____ 1A 1B 2 3
Details: _____
Routine H/N TB Brain ToH Arms: Up Down
Other: _____
Date:_____ PET Dr. Initial:_____

INCOMPLETE REFERRALS WILL BE RETURNED

Patient Information **Important:** **Height** _____ **Weight** _____ (kg / lb)
Name: _____ Preferred Name:_____
Surname First Middle
Date of Birth: D_____ M_____ Y_____ PHN: _____ Sex: Male / Female
Home Address: _____
Home Phone: ( ) _____ Work: ( ) _____ Mobile: ( ) _____
Temporary Address: _____ Temporary Phone:( ) _____
Family Physician: _____ Phone: ( ) _____
Patient mobility: ambulatory / wheelchair / stretcher

Diagnosis/Pertinent History
(include recent surgery, chemotherapy, radiotherapy):

If applicable, Clinical Trial Name: _____
Radiotracer Requested: _____
Contact Person: _____
Phone Number: _____

Specific Indication for PET/CT Request

Essential Information

			Additional Information
Does patient require an interpreter?	Y ☐	N ☐	**Language:** _____
Does patient have any drug allergies?	Y ☐	N ☐	_____
Does patient have IV contrast allergies?	Y ☐	N ☐	_____
CT scan within 3 months?	Y ☐	N ☐	**Date:** _____
MRI scan within 3 months?	Y ☐	N ☐	**Date:** _____
Nuclear Med scan within 3 months?	Y ☐	N ☐	**Date:** _____
Previous PET or PET/CT scan?	Y ☐	N ☐	**Location/date:** _____

Doctor's Signature: _____ **MSP No**: _____

Additional Copies of Report to: _____

BC CANCER
Provincial Health Services Authority

PET/CT REQUISITION - Victoria

Functional Imaging – Victoria
PET Reception: (250)519-5754
PET Fax: (250)519-5458

Current Date: _____
Referring Physician: _____
Phone: _____
Fax: _____

For Department use only

Scan Date:_____Time: _____
Indication #:_____ 1A 1B 2 3
Details: _____
Routine H/N TB Brain ToH Arms: Up Down
Other: _____
Date: _____ PET Dr. Initial: _____

Clinical Trial Information (if applicable)
Clinical Trial Name: _____
Radiotracer Requested: _____
Contact Person: _____
Phone Number: _____

Patient Information **Important: Height** _____ **Weight** _____ (kg / lb)
Name: _____ Preferred Name:_____
Surname First Middle
Date of Birth: D_____ M_____ Y_____ PHN: _____ Sex: Male / Female
Home Address: _____
Home Phone: ( ) _____ Work: ( ) _____ Mobile: ( ) _____
Temporary Address: _____ Temporary Phone:( ) _____
Family Physician: _____ Phone: ( ) _____
Patient mobility: ambulatory / wheelchair / stretcher

Diagnosis/Pertinent History
(include recent surgery, chemotherapy, radiotherapy):

Specific Indication for PET/CT Request

Essential Information

			Additional Information
Does patient require an interpreter?	Y ☐	N ☐	**Language:** _____
Does patient have any drug allergies?	Y ☐	N ☐	_____
Does patient have IV contrast allergies?	Y ☐	N ☐	_____
CT scan within 3 months?	Y ☐	N ☐	**Date:** _____
MRI scan within 3 months?	Y ☐	N ☐	**Date:** _____
Nuclear Med scan within 3 months?	Y ☐	N ☐	**Date:** _____
Previous PET or PET/CT scan?	Y ☐	N ☐	**Location/date:** _____

Doctor's Signature: _____ **MSP No**: _____

Additional Copies of Report to: _____

BC Cancer – Victoria
2410 Lee Avenue
Victoria, BC V8R 6V5
www.bccancer.bc.ca

Interdisciplinary Assessment

PASERO OPIOID INDUCED SEDATION SCALE

Place Patient Label Here

Scale	Intervention
S – Sleep, easy to arouse	*Acceptable; no action necessary; may increase opioid dose if needed*
1 – Awake and alert	*Acceptable; no action necessary; may increase opioid dose if needed*
2 – Slightly drowsy, easily aroused	*Acceptable; no action necessary; may increase opioid dose if needed*
3 – Frequently drowsy, arousable, drifts off to sleep during conversation	*Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50%[b] or notify primary[c] or anesthesia provider for orders; consider administering a non-sedating, opioid-sparing non-opioid, such as acetaminophen or an NSAID, if not contraindicated; ask patient to take deep breaths every 15 to 30 minutes.*
4 – Somnolent, minimal or no response to verbal and physical stimulation	*Unacceptable; stop opioid; consider administering naloxone[d,e]; stay with patient, stimulate and support respiration as indicated by patient status; call Rapid Response Team (Code Blue) if indicated; notify primary[c] or anesthesia provider; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.*

[a] Appropriate action is given in italics at each level of sedation.

[b] If opioid analgesic orders or a hospital protocol do not include the expectation that the opioid dose will be decreased if a patient is excessively sedated, such orders should be promptly obtained.

[c] For example, the physician, nurse practitioner, advanced practice registered nurse, or physician assistant responsible for the pain management prescription.

[d] For adults experiencing respiratory depression give intravenous naxolone very slowly while observing patient response (*titrate to effect*). If sedation and respiratory depression occurs during administration of transdermal fentanyl, remove the patch; if naloxone is necessary, treatment will be needed for a prolonged period, and the typical approach involves a naloxone infusion. Patient must be monitored closely for at least 24 hours after discontinuation of the transdermal fentanyl.

[e] Hospital protocols should include the expectation that a nurse will administer naloxone to any patient suspected of having life-threatening opioid-induced sedation and respiratory depression. *NSAID,*Nonsteroidal anti-inflammatory drug.

Date (DD-MM-YY):													
Time:													
Respiratory Rate:													
Pasero Opioid Induced Sedation Scale:													
Initials:													

Place Patient Form Label Here

TRANSFER OF IN-PATIENTS TO BC CANCER OUT-PATIENT AREAS PROCEDURE CHECKLIST

Transfer Note

CONFIRM APPOINTMENT

PRE-PLANNING

Facility: _____ **Unit:** _____ **Name of Staff at Sending Facility:** _____

BC Cancer Appointment Date: _____ **Time:** _____

Location for Appointment Today:

☐ **NP/Physician in clinic** ☐ **Radiation therapy** ☐ **Chemotherapy**

☐ **Contact Info Provided to Sending Facility**

***BC Cancer nurse will contact in patient unit (24-48 hours in advance) to ascertain if patient is well enough to travel for appointment, inform the in-patient unit that BC Cancer is an out-patient facility only and determine if nurse accompaniment is needed**

GATHER PATIENT INFORMATION

PATIENT INFORMATION ☐ **Patient is in-patient**

Patient Diagnosis/Reason for Admission:

History of:

Diabetes? ☐ Yes ☐ No

Cardiac Disease? ☐ Yes ☐ No

Implanted Devices: _____

Code Status:

☐ Full Code

☐ Do Not Resuscitate - Level

☐ Advance Care Plan

Allergies: _____

Alerts/Risks (e.g. Falls risk, Violence):

Infection Control:

☐ MRSA ☐ C. Diff

☐ VRE

☐ Other: _____

Interpreter Required:

☐ Yes _____ (Language)

☐ No

Family:

Aware of appointment: ☐ Yes ☐ No

Attending appointment: ☐ Yes ☐ No

Mental Status:

Able to provide Consent ☐ Yes ☐ No

Able to follow commands ☐ Yes ☐ No

Certified under the Mental Health Act ☐ Yes ☐ No

Substitute Decision maker ☐ Yes ☐ No

Patient Comfort:

☐ Consider if patient needs pain medication prior to transfer

☐ Consider if patient has anxiety (e.g. radiation therapy) and needs medication

Transportation: ☐ Booked

☐ Ambulance

☐ Local Transport Company

☐ Pt. Escort

☐ Return Transportation Booked

Travelling by:

☐ Bed

☐ Stretcher

☐ Wheelchair

Bowel and Bladder:

☐ Foley Urinary Catheter

☐ Nephrostomy/ Ileostomy/ Colostomy/ Incontinence

Mobility:

☐ Able to walk

☐ Able to stand and transfer

☐ Requires assistance

☐ 1 or 2 person transfer

☐ Require mechanical lift

☐ Able to lie flat

TRANSFER OF IN-PATIENTS TO BC CANCER OUT-PATIENT AREAS PROCEDURE CHECKLIST

Transfer Note

Place Patient Form Label Here

IDENTIFY PATIENT CARE NEEDS

PATIENT CARE NEEDS: BC Cancer Requirements
Assess whether patient is stable enough to meet the following criteria. If NOT, discuss with BC Cancer Physician/NP

☐ ***if appointment can be changed or***
☐ ***an alternative can be arranged***
☐ ***Oncologist can go to in-patient unit. PATIENT MAY BE TOO ACUTELY ILL TO TRAVEL.***

☐ **IV therapy:** ☐ **Not on IV therapy**
- ☐ Assessed and can be capped
- ☐ Assessed and cannot be capped (e.g. Heparin infusion)***
- ☐ Heparin infusion

☐ **NG tube to suction:** ☐ **No NG to suction**
- ☐ Assessed and patient too sick to travel (Rebook appointment or discuss alternatives)
- ☐ Assessed and patient accompaniment will be needed (Nurse)
- ☐ Assessed and NG attached to portable suction***
- ☐ Assessed and patient can tolerate no suction

☐ **Enteral Feeds:** ☐ **Not on enteral feeds**
- ☐ Assessed and can be capped (if patient condition allows)
- ☐ Assessed and cannot be capped due to patient condition

☐ **Oxygen therapy:** ☐ **Not on oxygen therapy**
- ☐ Assessed and patient not stable for travel (Rebook appointment or discuss alternatives)
- ☐ Assessed and patient accompaniment will be needed (Nurse/RT)
- ☐ Assessed and patient stable to travel to BC Cancer with portable oxygen tank
- ☐ Oxygen: Nasal Prongs _____ L/min Mask _____ L/min O_2 Sat _____

☐ **Negative Pressure Wound Therapy (NPWT):** ☐ **Not on NPWT**
- ☐ Assess and can be turned off
- ☐ Assessed and cannot be turned off
- ☐ Location of wound _____

☐ **Specialty surface needed:**
Consider if patient can be transferred via regular bed, stretcher or wheelchair.

OR NURSE ACCOMPANIMENT REQUIRED
(In some circumstances nurse may not need to stay but need proper handover):

- ☐ Inotropic infusions
- ☐ Opioid infusions
- ☐ Pain not well managed
- ☐ Tracheostomy: (Suction supplies, safety kit & RT)
- ☐ Ventilator
- ☐ Chest Tube (Safety kit)
- ☐ Locked restraints
- ☐ Threat to self or others
- ☐ Certified under the Mental Health Act
- ☐ Elopement risk: PCA may be appropriate
- ☐ Pacemaker - external
- ☐ Paracentesis

RT ACCOMPANIMENT REQUIRED

- ☐ Unstable or compromised airway
- ☐ High oxygen requirement
- ☐ Mechanically ventilated

Medications:
- Instructed to send MAR (or copy) with patient: ☐ Yes (not optional)
- Administration of medications required during visit: ☐ No ☐ Yes *(*document below) - Medication dispensed by the sending facility must be administered by the accompanying nurse.*
- Details: _____

Medication Administration while Patient is at BC Cancer:
- Host facility or sending nurse (if the nurse accompanies the patient) will administer any medication accompanying the patient
- New orders written by BC Cancer physician can be administered by sending facility staff if the BC Cancer physician has privileges in the sending facility
- Medication administered by the accompanying facility nurse will be documented in the sending facility chart. BC Cancer nurses will document in the BC Cancer patient record and on communication handover form

Completed by _____ **Designation:** ☐ **RN** ☐ **LPN** ☐ **Date** _____ **Day 1**

Initial _____ **Date** _____ **Day 2** ☐ **no change; checklist information remains current**

Initial _____ **Date** _____ **Day 3** ☐ **no change; checklist information remains current**

Initial _____ **Date** _____ **Day 4** ☐ **no change; checklist information remains current**

Initial _____ **Date** _____ **Day 5** ☐ **new checklist must be completed**

PRINT | Clear form

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LOWER MAINLAND MRI REQUISITION

Fax OUTPATIENT Requisition to MRI Central Intake: 1-866-588-6955

DEPARTMENT USE ONLY	
Requisition Received Date: Time:	Appointment Date: Time:

IMPORTANT: MRI requests will be assigned to a lower mainland site with the earliest appropriate appointment time unless a preferred site is indicated. Yellow highlighted fields must be completed to avoid delays in patient processing.

PATIENT INFORMATION

LAST NAME	FIRST NAME	PERSONAL HEALTH NUMBER
ADDRESS	CITY PROVINCE POSTAL CODE	DATE OF BIRTH YYYY MM DD
PRIMARY PHONE / ALTERNATE PHONE	EMAIL	Patient consents to appointment information being disclosed to them in a text or email message ☐ Yes, text ☐ Yes, email ☐ No
HEIGHT (CM) / WEIGHT (KG) / SEX	INFECTION CONCERNS ☐ MRSA ☐ C.diff ☐ VRE ☐ Active TB ☐ Other:	INTERPRETER REQUIRED ☐ No ☐ Yes, specify language:
MOBILITY REQUIREMENTS ☐ Ambulance ☐ Wheelchair ☐ Mechanical Lift	BILL TO ☐ MSP insured ☐ ICBC ☐ WSBC ☐ Patient ☐ Other:	ICBC/WSBC NUMBER

EXAM INFORMATION AND HISTORY

EXAM REQUESTED (Appropriateness checklist must accompany referrals for lumbar spine, knee and hip)	PREFERRED MRI SITE (indicating a site may result in a longer wait time)
REASON FOR EXAM / RELEVANT CLINICAL HISTORY (include any relevant medications)	RELEVANT PREVIOUS EXAMS ☐ MRI ☐ CT ☐ X-Ray ☐ Ultrasound ☐ Nuclear Medicine ☐ Angiogram Specify dates and locations

SAFETY SCREENING (must complete for all MRI exams requested)

Patient pregnant	☐ No	☐ Yes	Cerebral Aneurysm Clip	☐ No	☐ Yes, type:
Internal Electrodes or Wires	☐ No	☐ Yes	Middle Ear Prosthesis	☐ No	☐ Yes, type:
Neurostimulator	☐ No	☐ Yes	Intravascular Stent/Filter	☐ No	☐ Yes, type:
Metallic Orbital Foreign Body	☐ No	☐ Yes	Breast Tissue Expander	☐ No	☐ Yes (not breast implants), type:
Implanted Infusion Pump	☐ No	☐ Yes	Patient claustrophobic	☐ No	☐ Yes, prescribe sedation
Shrapnel and/or Bullet	☐ No	☐ Yes where:	Cardiac Pacemaker/Defibrillator	☐ No	☐ Yes, type:

EXAMS REQUIRING CONTRAST

Patient is over 60	☐ No	☐ Yes
Diabetes or hypertension	☐ No	☐ Yes
Severe hepatic disease	☐ No	☐ Yes
Liver transplant	☐ No	☐ Yes
PICC line / IV problems	☐ No	☐ Yes

If yes to any above, please indicate the most recent eGFR results and the date it was obtained. Current eGFR within 3 months of appointment may be required if contrast is given. **Most MSK, spine, and routine neuro exams do not require contrast.**

eGFR result: Date:

CLINICIAN INFORMATION

REQUESTING CLINICIAN NAME	MSP BILLING NUMBER	CLINICIAN PHONE	CLINICIAN FAX
REQUISITION SUBMISSION DATE YYYY MM DD	COPY REPORT TO (FIRST AND LAST NAME)	MSP BILLING NUMBER	COPY TO FAX NUMBER

TECHNOLOGIST NOTES	RADIOLOGIST PROTOCOL AND PRIORITY
	☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Specified Date:

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LOWER MAINLAND MRI APPROPRIATENESS CHECKLIST

Fax OUTPATIENT Requisition to MRI Central Intake: 1-866-588-6955

IMPORTANT: The following information is required in order for us to process your request. Yellow highlighted fields must be completed to avoid delays in patient processing. **Please include the MRI appropriateness checklist with the MRI requisition.**

PATIENT INFORMATION

LAST NAME			FIRST NAME
DATE OF BIRTH			PERSONAL HEALTH NUMBER
YYYY	MM	DD	

MRI LUMBAR SPINE APPROPRIATENESS CRITERIA

The purpose of an MRI for lumbar spine is to identify suspected disc herniation, nerve compression, or metastatic disease. The most common cause of low back pain is mechanical and will resolve itself within 12 weeks. **Complete the checklist for all adult patients (18 years of age and older) referred for MRI lumbar spine.** One or more of the following **must** apply in order to be eligible for MRI lumbar spine:

- ☐ MRI was recommended on a previous imaging report (please attach report)
- ☐ Previous lumbar spine surgery
- ☐ Cauda equina syndrome
- ☐ Unexplained weight loss, fever or immunosuppression
- ☐ History of cancer or suspected cancer
- ☐ Use of IV drugs or steroids
- ☐ Any neurologic symptoms
- ☐ Significant acute traumatic event immediately preceding onset of symptoms
- ☐ Age over 65 with first episode of severe back pain
- ☐ Pain lasting 12 weeks or longer

If the patient meets the lumbar spine appropriateness criteria, indicate if the patient is experiencing:

- ☐ Back dominant pain (Pain above gluteal fold and below the T12 rib)
- ☐ Leg dominant pain (Below the gluteal fold, specific root distribution and radiation below the knee)

MRI KNEE and HIP APPROPRIATENESS CRITERIA

The purpose of an MRI for knee or hip is primarily for surgical planning. In most cases, using MRI does not add useful information for patients with moderate-to-severe osteoarthritis (OA) especially for those with chronic degenerative conditions. A weight-bearing x-ray is recommended to identify OA. **Complete the checklist for patients 40 years of age and older referred for MRI knee or hip.** One or more of the following **must** apply in order to be eligible for MRI knee or hip:

- ☐ MRI was recommended on a previous imaging report (please attach report)
- ☐ Previous knee or hip surgery
- ☐ Suspected infection
- ☐ Suspected tumour
- ☐ Osteonecrosis
- ☐ Fixed locked knee
- ☐ Patient has had a weight-bearing x-ray within the past 6 months and referring clinician has confirmed mild or no evidence of osteoarthritis in the knee or hip

CLINICIAN INFORMATION

REQUESTING CLINICIAN NAME	MSP BILLING NUMBER	CLINICIAN PHONE	CLINICIAN FAX

Appropriateness criteria are consistent with the Choosing Wisely Canada recommendations. For more information, visit https://choosingwiselycanada.org.

For appropriateness guidance from a radiologist, call the Rapid Access to Consultative Expertise (RACE) line: 1-604-696-2131 or visit http://www.raceconnect.ca/.

Information for referring clinicians on MRI appropriateness can be found at: http://www.vch.ca/MRI-Central-Intake and https://pathwaysbc.ca.

BCHA.0100 | OCT.2018

BC CANCER
Provincial Health Services Authority

DIAGNOSTIC IMAGING REQUISITION

Vancouver Centre

604-877-6000
- Reception x 67.2274
- CT Booking x 67.2280 Fax: 604-877-6063
- Breast Booking x 67.2285 Fax: 604-877-6063

Patient Name:	Appointment Date/Time:

BCCA #: Address: Phone(1): Phone(2):

Location: OPD _____ IP/Ward _____ Post Exam: ACU MDC Home

Interpreter Required: ____ ☐ Arranged

☐ Infection Precaution: ☐ MRSA ☐ VRE ☐ RESP ☐ Patient Notified ☐ Instructions ☐ Non MSP

► *History / Clinical query* ◄

► *Patient details* ◄

Cr: _____ eGFR: _____ Date: _____

☑ serum Cr within 3 months (if ≥ 19 yrs for CT; if ≥ 60 yrs for MRI)

Age: _____

Allergies: _____

Previous Contrast Reaction: _____

☐ Diabetic ☐ Pregnant

☐ Dialysis ☐ Breastfeeding

☐ Metformin ☐ LMP _____

Exam requested

☐ X-Ray ☐ Review of outside

☐ CT ☐ Biopsy

☐ US ☐ _____

☐ Mammo

OF

_____ site(s)

► *Staff* ◄ ► *House staff* ◄

Print : _____ _____

Sign: _____ _____

Copies to: _____

Booking use only

Date Received: _____

Priority Level: ☐ 1 ☐ 2 ○ ☐ 3 ☐ 4

Timed follow up exam — Specified procedure date

Relevant outside previous studies

Book prior to FUP/Rx on: _____ date

Book within: _____ days

Protocol (Radiologist Use Only)

○ H ☐ IAC ☐ Stereo ☐ BOS ☐ Sella ☐ Cranio ☐ US

▯ N ☐ CT

△ C ☐ Lung Ca PE

☐ A ☐ Liver 3-P / 4-P ☐ GU ☐ low-dose ☐ Core

▽ P ☐ Rectum ☐ Gyne ☐ FNA

☐ C T L Spine MSK Skeletal survey ☐ INR/PTT/CBC Bed

☐ Breast ☐ Ca ☐ Scr ☐ H_2O prep

☐ C+ pending GFR ☐ C+ ☐ C-

☐ △ dose / hydrate

MD: _____ Contrast: _____ Tech: _____

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

Community Referral Form

VANCOUVER ISLAND health authority
Vancouver CoastalHealth — Promoting wellness. Ensuring care.
fraserhealth — Better health. Best in health care.

Referral form Instructions:
1) Please complete the fax cover page in addition to this referral form
2) Fax cover page, referral form and required documentation to the location indicated in the fax cover page header
3) For urgent referrals, phone referred agency to ensure form(s) are received

Date: _____
BCCA #: _____
PHN #: _____
PARIS #: _____

PATIENT DETAILS

Name: _____ (last name, first name) Gender: ☐ Male ☐ Female ☐ Trans

Permanent Address: _____ Postal: _____

Tel: _____ DOB: _____ Age: _____ ☐ Aboriginal ☐ Acquired Brain Injury

Temporary Address: _____ Temp Tel: _____

Primary Contact: _____ Relationship: _____ Tel: _____ Cell: _____

PATIENT COMMUNICATION

Language: _____ English Comprehension: ☐ Yes ☐ No ☐ Unknown

Need for translator? ☐ Yes ☐ No Name: _____ Tel: _____
Cognitive Impairment? ☐ Yes ☐ No

ADL
☐ Independent
☐ Assist
☐ Dependent

MOBILITY
☐ Independent
☐ 1 person assist
☐ 2 person assist
☐ Dependent

DIAGNOSIS:

Dx Date: _____

Patient/Family aware of diagnosis? ☐ Yes ☐ No ☐ Unknown

PROGNOSIS: ☐ >1Yr ☐ <1YR ☐ <6MTHS ☐ <3MTHS ☐ WKS
PPS %: _____ ECOG: _____

Other Illness(es) Present:

PRIORITY LEVEL OF INITIAL CONTACT

Nursing: ☐ within 24hrs ☐ within 48hrs ☐ up to 1wk
OT ☐
PT ☐

Reason for Urgency if within 24-48hrs:

REASON FOR REFERRAL (*check all applicable*)

☐ IV/PICC line care ☐ D/C Chemo
☐ Wound care
☐ Intro to community home care and services
☐ Home support services for personal care
☐ Change in Medications or New Medications
☐ Safety assessment
☐ Unacceptable level of pain Pain scale: __/10
☐ Reporting worsening symptoms of fatigue, weakness or SOB, nausea
☐ Unmanaged psychosocial issues regarding their palliative status
☐ Transitioning to comfort care
☐ Needing assessment for end-of-life care

PRESENT TREATMENTS

Goals of Treatment: ☐ Curative ☐ Palliative

☐ Chemotherapy
☐ Radiation Therapy
☐ Hemodialysis
☐ Peritoneal Dialysis
☐ TPN
☐ Blood Transfusions
☐ Complimentary Alternative Medicine
☐ No further active treatment offered
☐ Enteral Feeding
☐ Oxygen
☐ Pleurx Catheter Drainage
☐ Thoracentesis
☐ Paracentesis

Next Appointment: Date: Time:

CARE PROVIDERS INVOLVED

General Practitioner: _____ Tel: _____ Pager: _____

Radiation Oncologist: _____ Tel: _____ Pager: _____

Medical Oncologist: _____ Tel: _____ Pager: _____

Specialist: _____ Tel: _____ Pager: _____

INFORMATION TO BE SENT WITH REFERRAL (*check applicable*)

☐ BC Cancer Agency ROI *(if BCCA, check here only)*
☐ Recent Consultations
☐ History & Physical or case summary within last 30 days
☐ Signed BC Palliative Care Benefits
☐ Physician order
☐ Present MAR or medication list
☐ Social Service history

ADDITIONAL INFORMATION

BC Provincial No CPR form signed ☐ Yes ☐ No
Patient is aware of this referral ☐ Yes ☐ No
Family is aware of this referral ☐ Yes ☐ No
My Voice / Advance Directives ☐ Yes ☐ No

Health Provider: _____
Date Discussed: _____

GOALS OF CARE

PERSON SUBMITTING REFERRAL

Name: _____ Title: _____ Department: _____

Tel: _____ Ext: _____ Pager: _____ Fax: _____

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

DEPARTMENT OF DIAGNOSTIC IMAGING
Requests for Image/Film Records

Patient: _____

Birthdate: _____

BCCA #: _____

To: _____

_____

_____

Phone#: _____

Contact: _____

Comments: _____

_____

_____

Initial/Date: _____

BCCA-DX57 Rev April/2006

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

DEPARTMENT OF DIAGNOSTIC IMAGING
Requests for Image/Film Records

Patient: _____

Birthdate: _____

BCCA #: _____

To: _____

_____

_____

Phone#: _____

Contact: _____

Comments: _____

_____

_____

Initial/Date: _____

BCCA-DX57 Rev April/2006

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

DEPARTMENT OF DIAGNOSTIC IMAGING
Requests for Image/Film Records

Patient: _____

Birthdate: _____

BCCA #: _____

To: _____

_____

_____

Phone#: _____

Contact: _____

Comments: _____

_____

_____

Initial/Date: _____

BCCA-DX57 Rev April/2006

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

DEPARTMENT OF DIAGNOSTIC IMAGING
Requests for Image/Film Records

Patient: _____

Birthdate: _____

BCCA #: _____

To: _____

_____

_____

Phone#: _____

Contact: _____

Comments: _____

_____

_____

Initial/Date: _____

BCCA-DX57 Rev April/2006

VCH.0059B
JAN.2022

VANCOUVER COASTAL HEALTH
TRANSFUSION MEDICINE SERVICE (TMS)

REQUISITION

TM TESTING, RED CELL & PLATELET PRODUCT REQUEST

☐ VGH ☐ UBCH ☐ LGH ☐ RH ☐ SH ☐ SGH ☐ WHCC ☐ PEMB
☐ BCCA ☐ BCGH ☐ RWL ☐ PRGH

DATE | NURSING UNIT

MR. MISS, MRS | UNIT NUMBER

SURNAME | GIVEN NAME

DOCTOR | (PLEASE USE BLOCK CAPITALS)

DIAGNOSIS

☐ **Antepartum** ☐ **Intrapartum** ☐ **Postpartum** ☐ **N/A**

ORDERING PHYSICIAN

PREADMISSION PATIENTS ONLY
Complete Pre Surgical Screening Questions

SECTION 1 - TESTING

GROUP AND SCREEN ☐ STAT
☐ Routine

COMPLETE FOR PRE SURGICAL SCREENING PATIENTS ONLY

Has patient been pregnant in past 90 days? ☐ Yes ☐ No ☐ Unknown
Has patient been transfused with Red Cells or Platelets in past 90 days? ☐ Yes ☐ No ☐ Unknown

OTHER TESTS ☒ Routine
☐ Direct Antiglobulin Test (DAT) ☐ Red Cell Phenotyping ☐ Other (Requires TM Approval): Specify _____

SAMPLE COLLECTION:

Patient identification provided by:
☐ Patient OR ☐ Alternate (write name): _____

Collection Date: _____ Time: _____

Collected By: _____ Initials: _____
Print Name or LAB Code

SECTION 2 - PRODUCT REQUEST *(Downtime use only)*

PRIORITY: ☐ STAT ☐ Routine Date required: _____ / _____ / _____ Time: _____

SPECIAL REQUIREMENTS (MUST COMPLETE)

☐ No special requirements
☐ Irradiated ☐ Discontinue request for irradiated

RED BLOOD CELL REQUEST - See reverse for additional information

Consider emergency group O for urgent transfusion - contact TM

☐ AMOUNT REQUIRED: _____ units *Group & Screen must be completed within past 4 days*

INDICATION Hb _____ g/L Date: _____

☐ Anemia & bleeding ☐ Bleeding & hypotensive
☐ Anemia - symptomatic ☐ Trauma
☐ Anemia - chronic

PLATELET REQUEST

☐ AMOUNT REQUIRED: **1 Adult Dose** *Confirm Group & Screen status with TM*

INDICATION Plt count _____ 10^9/L Date: _____

☐ Platelets less than 100 x 10^9/L Neurosurgery; CNS Trauma
☐ Platelets less than 50 to 80 x 10^9/L Epidural Catheter Insert/Removal
☐ Platelets less than 50 x 10^9/L, and significant microvascular bleeding or surgery
☐ Platelets less than 20 x 10^9/L and fever, or coagulopathy
☐ Platelets less than 10 x 10^9/L, marrow failure
☐ Known platelet dysfunction and high risk of bleeding

TMS Sample Labels		Number of Samples	Computer Record	Archive Record	Comments	Tech.
			ABO/Rh			

TM ONLY

Test/Request	Time (Approx and based on receipt of sample in TM)	What is Provided	Risk to Patient when transfused
TESTS Group and Screen	Site Specific	Patient ABO/Rh Group is determined. Antibody screen is completed to determine the presence of irregular antibodies. Select when routine Group and Screen is required and transfusion is not imminent.	No additional risk **NB:** If irregular antibodies are detected, antibody investigation will be initiated.
TESTS Group and Screen STAT	60 mins	Testing as above. Results available within 60 minutes. Select when blood may be required within 60-90 minutes.	As above
RED CELLS Site Specific VGH/UBC/LGH/RH ALL OTHER SITES	Min 10 mins Min 45 mins	Red Cells are assigned and tagged ready for pick-up. Select when blood is to be transfused as soon as Group and Screen is complete. NB: Antibody screen must be negative.	No additonal risk Serological crossmatching is required for patients with antibodies and require additional time
Requesting Physician assumes responsibility for Unmatched Blood for emergency transfusion.			
RED CELLS Group Specific Group complete Group and Screen incomplete	15 mins	Patient ABO/Rh Group is determined. Antibody screen will be incomplete at time of Red Cell issue. Select when blood is required urgently (within 15 mins). Antibody Screen will be completed on STAT basis. If antibody screen is positive, Patient Care Unit will be notified.	Patient may exhibit acute or delayed reaction to transfused Red Cells. If time allows group specific Red Cells should be requested instead of Group O in order to conserve emergency blood supply.
RED CELLS Group O Group and Screen incomplete	5 mins	Patient Group and Screen is not available. Universal Donor, Group O red cells are assigned for patient. Select when transfusion is required immediately. STAT Group and screen sample required immediately. If antibody screen is positive, Patient Care Unit will be notified.	As above. Consult with TMS for guidelines related to emergency or massive transfusion. NB: Whenever possible obtain sample for STAT Group and Screen prior to transfusion of Group O Cells

Place Patient Form Label Here

MORSE
FALL RISK ASSESSMENT & CARE PLAN

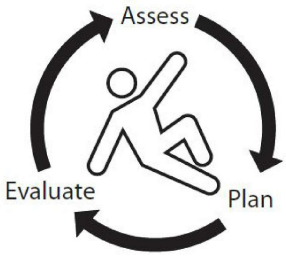
Interdisciplinary Care Plan

Morse Fall Scale: (circle score)

History of Falls (last 3 months)	No Yes	0 25
Secondary Diagnosis	No Yes	0 15
Ambulatory Aid	None/bed rest/lift/wheelchair Crutches/cane/walker Furniture	0 15 30
IV or IV lock (any lines/tubes)	No Yes	0 20
Gait	Normal/bed rest/immobile Weak Impaired	0 10 20
Mental Status	Oriented to own ability Forgets limitations	0 15
Morse Fall Score =		**/125**

Assessment on: (check one)

- ☐ Admission
- ☐ Transfer
- ☐ Significant Change in Status



If Morse Fall Score = 45 or more, patient is at high risk for falls, please complete the following:

	Detailed Fall Risk Assessment	Fall Prevention CARE PLAN
History of Fall in last 3 months	☐ Recent fall within 90 days?	☐ Increase supervision ☐ _____ ☐ _____
Secondary Diagnosis / Health Status	☐ Postural hypotension ☐ Exacerbation chronic illness ☐ Irregular heart rate/rhythm/oxygenation ☐ Muscle weakness/decreased coordination ☐ Poor proprioception ☐ Foot problems	☐ After period of bed-rest, patient needs to sit for a few minutes prior to standing ☐ Hip protectors needed ☐ If systolic drops more than 20mmHg from sitting to standing or lying to sitting, notify NP/MD ☐ _____
Gait / Functional Mobility / Ambulatory Aids	☐ Gait, balance, mobility, transfer impaired ☐ Lack of ability to use mobility aids &/or wheelchair safely ☐ Change in weight-bearing status &/or new assistive aids ☐ Requires assistance for toileting & bathing ☐ Lack of proper footwear	☐ Assistance for transfers to/from bed/wheelchair/toilet/commode ☐ Ensure bed/chair brakes are on for transfers ☐ Encourage ambulation with assistance/supervision ☐ Mobility aid needed & within reach ☐ Non-slip socks/well-fitting shoes with enclosed heel available ☐ Bed in lowest position ☐ Call bell within reach ☐ _____
IV or IV Lock/ Environmental Barriers	☐ Lack of lighting ☐ Tripping hazards (IV pole, clutter, lines, tubes)	☐ Personal items within reach ☐ Patient's room is free of obstacles & clutter ☐ Assess environment for tubes, lines, furniture, equipment hazardous to mobilization ☐ _____
Mental Status	☐ Agitation, aggression, pacing, anxiety ☐ Delirium, dementia, psychosis, ☐ Developmental delay ☐ Lack of insight &safety awareness ☐ Impulsiveness ☐ Neurological/brain injury	☐ Bottom bed rails are down ☐ Familiarize patient to surroundings ☐ Move patient closer to nursing station ☐ 1:1 supervision ☐ Bed/chair alarm ☐ _____ ☐ _____

See reverse

Place Patient Form Label Here

MORSE
FALL RISK ASSESSMENT & CARE PLAN

Interdisciplinary Care Plan

	Detailed Fall Risk Assessment	Fall Prevention CARE PLAN
Vision / Sensory Impairment	☐ Altered ability to see (macular degeneration, glaucoma, cataracts) ☐ Visually impaired to the extent that everyday function is affected ☐ Impaired hearing ☐ Uses hearing aids	☐ Remove clutter/physical hazards ☐ Patient has appropriate eyewear within reach ☐ Patient has hearing aids in, turned on and batteries are working ☐ _____
Bowel/Bladder	☐ Altered elimination, urgency, frequency, rushing to the toilet	☐ Individual Toileting schedule/plan in place ☐ Review medications that cause urgency ☐ Fluid management plan ☐ Clutter-free access to bathroom ☐ Assistance needed for toileting: ☐ Night ☐ Day ☐ Commode/urinal at bedside ☐ _____ ☐ _____
Communication	☐ Language barrier ☐ Sensory impairments - poor vision/ hearing	☐ Translator required: _____ ☐ Education on use of call-bell ☐ _____
Fear of falling	☐ Expressed fear of falling that compromises recovery	☐ Encourage safe physical activity as possible ☐ Collaborate with patient & family to address fears ☐ _____
Medications	☐ On medications that increase risk of falling (psychotropic, sedatives, anti-coagulants, antihypertensives, opioids, diuretics) ☐ Potentially inappropriate medication use	☐ Assess meds known to increase Fall risk & modify where possible ☐ Minimize total amount of medication ☐ Lowest effective dose used ☐ Non-pharmacological strategies to improve sleep ☐ Review timing of high-risk medication administration ☐ _____
Nutrition/Hydration	☐ Recent weight loss ☐ History of poor/sub-optimal intake ☐ Poor fluid intake ☐ History of osteoporosis	☐ Consult dietitian if patient is underweight or intake less than 75% for 3 consecutive meals ☐ Consultation with MD re: supplementation with calcium & vitamin D ☐ Offer minimum 1500 ml of fluids daily unless contraindicated ☐ _____
Pain	☐ Musculoskeletal/neurological condition(s) that produce pain & limit mobility (e.g., diabetic neuropathy) ☐ Pain interfering with ADLs ☐ Neurological conditions that limit ability to express pain	☐ Multifactorial pain assessment & treatment plan done ☐ Administer analgesics as needed to relieve pain & consider regular dosing ☐ Provide prn analgesic prior to mobilization & reassess ☐ _____
Substance Use	☐ Intoxication &/or withdrawal from alcohol, nicotine & drugs	☐ Monitor for drowsiness, dizziness & impaired balance/ gait/judgment ☐ _____

Date: _____ Signature: _____ Designation: _____

Place Patient Label Here

RESIDENT TRANSFER FORM: CARE FACILITY TO EMERGENCY DEPARTMENT (ED)

Transfer Note

Sending Site Information	Contact Information
Facility Name:_____ Unit Name._____	Name of Contact for Resident:_____
Direct Phone Number Days:_____ Ext:_____	Phone:_____ Relationship to Resident:_____
Evenings:_____ Ext:_____	Notified of Transfer: ☐ Yes ☐ No
Nights:_____ Ext:_____	GP/NP Name: _____ Phone:_____
ED notified of transfer: ☐ Yes ☐ No	Notified of Transfer: ☐ Yes ☐ No/Reason:

Safety/Alerts *(Detailed comments to be added to SBAR section)*

Greensleeve Documents Attached: ☐ Yes ☐ No If no, explain:_____Palliative ☐ Yes ☐ No

Allergies: ☐ Yes ☐ No → include reactions:_____ ☐ NPO →date started_____ ☐ Falls Risk

Infection Control Concerns: ☐ Yes ☐ No If yes: ☐ MRSA ☐ C Diff ☐ Hepatitis: ☐ Other: _____

Outbreak in Facility: ☐ Yes ☐ No If yes: Type:_____ Symptoms: _____

Behaviour Concerns: ☐ Yes ☐ No If yes: ☐ Physical Aggression ☐ Verbal Aggression ☐ Elopement Risk ☐ Other:

Situation *(Reason for transfer):*

Background *(History of recent illness and relevant treatment including care team involvement e.g. Mental Health, Dialysis)*

Assessment *(Results of recent investigations/other relevant medical history/diagnoses/treatment)*

Recommendations *(Requested actions. Include resident specific helpful hints/care & behaviour strategies)*

Pre-Transfer Baseline Information (48/6 Screening)

Cognition: ☐ No Impairment ☐ Mild Impairment/Moderate Impairment ☐ Severe Impairment:_____
☐ Recent Change Cognition/Mood:_____ Language/Communication:_____

Pain: ☐ None ☐ New ☐ Chronic Location/s:_____ How Expressed:_____
Modalities Used to Manage Pain:_____

Nutrition/Hydration: Diet: _____ Texture:_____ Last Eaten:_____ Last Drink: _____
☐ Poor Appetite (over 1 week) ☐ Weight Loss (last 6 months) kg:_____Sudden Weight Gain kg:_____
☐ Swallowing Difficulties Feeding Assistance Required ☐ None ☐ Partial ☐ Complete Assistance
Fluids: ☐ Thin ☐ Thickened ☐ Tube Feed → ☐ Tube Feed Schedule Attached

Bowel/Bladder: Toileting Assistance: ☐ Yes ☐ No ☐ Bathroom ☐ Bed Pan ☐ Commode ☐ Urinal
Bowel ☐ Continent ☐ Incontinent Last Bowel Movement:_____
Bladder ☐ Continent ☐ Incontinent Last Voided:_____ ☐ Catheter → last changed date:_____
☐ Ostomy/Type:_____ Bowel/Bladder issues:_____

Mobility: ☐ Fallen in the last 3 months ☐ Fallen in the last 12 months
Mobility aids: ☐ None ☐ Cane ☐ Walker ☐ Wheelchair/Independent ☐ Wheelchair/With Assist
Transfers ☐ Independent ☐ With supervision ☐ 1 Person Assist ☐ 2 Person Assist ☐ Mechanical Lift/Type_____
Ambulation: ☐ Independent ☐ With supervision ☐ 1 Person Assist ☐ 2 Person Assist ☐ Non-ambulatory

Medications: MAR/Transfer Med List Attached: ☐ Yes ☐ No ☐ Flu Vaccine/Antiviral (type/date) _____
Any changes to medications in the last 2 weeks: ☐ Yes ☐ No If yes, explain_____
Medication Administration *(e.g. crushed, with pudding)*:_____

Pressure Ulcer Risk: Braden Scale Score:_____ Date:_____Therapeutic Device/Surface : _____
☐ Wound: Location _____ ☐ Packing In: number of pieces: _____ ☐ Clinician Report Attached

Personal Items Sent With Resident: ☐ Cane ☐ Glasses ☐ Walker ☐ Wheelchair ☐ Hip Protector
Dentures → ☐ Upper ☐ Lower Hearing aids → ☐ Left ☐ Right ☐ Other_____

Completed By (sign and print)/Professional Designation/ Direct Contact Number	Date of Transfer: Time:

Place Patient Label Here

RESIDENT TRANSFER FORM: CARE FACILITY TO EMERGENCY DEPARTMENT (ED)

Transfer Note

Residential staff to complete the following upon transfer to hospital

Sending Site Information:
Include the facility name and the unit where the resident resides. Include all direct telephone contact information so that ED can make contact easily with the resident's care facility. Indicate if contact was made with ED prior to transfer.

Contact Information: Include information as indicated. Note that "contact for resident" is not necessarily the health care decision maker. Include GP or NP name if GP or NP is not listed in the Addressograph area.

Safety/Alert:
This section includes **important** safety information to reduce the risk of harm and injury to residents and staff. Complete all sections as indicated. Elaborate with details in the SBAR section as needed. Include palliative status as "yes" if client is confirmed to have life limiting illness and deemed palliative by the physician. All residents should have greensleeve (or for Providence Health, blue sleeve) contents included such as: Advance Care Plan (ACP) and/or Medical Orders for Scope of Treatment (MOST) or Degree of Intervention (DOI), Representation Agreements, Advance Directive, etc. Please refer to your Health Authority Greensleeve policy. Include other relevant infection control information under 'other', with further details added to SBAR section.

SBAR:

		Examples:	Consider:
S	**Situation:** • A concise statement of the problem *What is going on right now*	*Immediate concern as:* • Injurious fall (indicate type and location of injury) • Change in level of consciousness • Respiratory distress • Increasing chest pain	• TPR and BP • O_2 Sats • Neurovital signs • Capillary blood glucose • Level of consciousness • Behaviour changes • Chest sounds • Skin colour • CWMS • Urine output/bladder scan
B	**Background:** • Brief information related to the situation *What has happened*	*Relevant medical history such as:* • Resident had recent previous surgery or medical treatment. (Explain in detail.)	• Previous baseline assessment/VS related to event • Relevant or important diagnosis and history • Contributing factors
A	**Assessment:** • Analysis and consideration of options *What you found/think is going on*	*What I think the problem is:* • I am not sure what the problem is, but the resident is deteriorating • The resident's pain is not in control • The resident is unstable and may get worse. We need to do something.	• Cardiac • Neurological • Respiratory • GI/GU • Musculoskeletal • Infection • Delirium/CAM
R	**Recommendation:** • Request/ recommend action *What you want done*	*I suggest or request that you:* • Investigate/diagnose the health issue • Review level of intervention	• Resident specific helpful hints • Care and behaviour strategies

Pre-Transfer Baseline Information:
This section should reflect the resident's typical baseline functioning **prior to the most recent medical decline or event.** Attach all documents as indicated. Under the pain section identify how the resident expresses pain, such as "cries out" or "hits others" and indicate the modalities used to treat pain such as "positioning" or "warm blanket". For the nutrition section, include the date and time of day that the resident last ate or drank. For bowel and bladder, indicate date and time of last void or bowel movement.

Personal Belongings:
Indicate all personal belongings being sent with the resident. Do not send valuables.

Attachments
- Greensleeve contents (PHC- Blue Sleeve)
- Medication Administration Record (MAR)
- Wound Care Clinician Report (or Wound Care Treatment Plan),
- Tube Feed Schedule, and
- Other attachments/instructions

Place Patient Label Here

POST ANESTHETIC RECOVERY RECORD

Postoperative Record

Phase 1 **PAR** ☐ **Phase 2** **Daycare-Fast Tracked** ☐

Date: Time:	Allergies: Yes ☐ No ☐
Anesthetist:	
Admitting Nurse (s):	

AIRWAY: N/A	Time	Initial	Time Removed	Initial
Oral				
Nasal				
Laryngealmask				
Endotracheal				
Nasotracheal				
Tracheostomy				

OXYGEN THERAPY: N/A Time	Mode	Concentration	Initial	Time off	Initial	Time	O_2Sat

ANESTHESIA TYPE
☐ General
☐ General with Regional (Pain Management)
☐ IV Conscious Sedation
☐ Monitored Anesthesia Care
☐ LOCAL
☐ BLOCK - Spinal
☐ BLOCK - Epidural
☐ BLOCK - Brachial
☐ BLOCK - Intravenous
☐ BLOCK - Axillary
☐ BLOCK - Regional
☐ BLOCK - BLOCK to General
☐ NONE

SKIN COLOR	
Normal	
Pale	
Cyanosed	
Flushed	
Diaphoretic	
Jaundiced	

POSITION O/A	
Left Lateral	
Right Lateral	
Supine	
Prone	
Trendelenberg	
Semi Fowlers	
High Fowlers	

MONITORS	
Pulse Oximeter	
Non Invasive BP	
ECG	
Arterial Line	
CVP	
Temperature	
ICP	
Other	
Neuro Assessment Required: See attached Neuro sheet	

Alteration In	Nursing Assessment Criteria		Pre-op					
	Assessment: Pre-op. On Transfer from Procedure Room to PAR/SSCU On transfer from PAR to Nursing Unit	**Assessment on Discharge from Daycare to Home**						
Level of Consciousness	2 Awake and orientated 1 Arouses with minimum stimulation 0 Responsive only to tactile stimulation/unconscious	2 Awake and orientated or equivalent to pre-op status 1 Arouses with minimum stimulation 0 Responsive only to tactile stimulation						
Physical Activity	2 Able to move all extremities on command 1 Some weakness in movement of extremities 0 Unable to voluntarily move extremities	2 Ambulates independently/consistent with surgical procedure or equivalent to pre-op level 1 Ambulates with assistance 0 Unable to ambulate						
Haemodynamic Stability	2 Blood Pressure 20% of baseline BP 1 Blood Pressure 20-40% of baseline BP 0 Blood Pressure 40% of baseline BP **Pre-op B/P**_____ **Pulse** _____	2 Blood Pressure 20% of baseline BP 1 Blood Pressure 20-40% of baseline BP 0 Blood Pressure 40% of baseline BP						
Respiratory Stability	2 Able to breathe deeply with good cough 1 Shallow or limited breathing 0 Dyspneic airway requires assistance	2 Able to breath deeply with good cough or equivalent to pre-op status 1 Shallow or limited breathing 0 Dyspneic airway requires assistance						
Oxygen Saturation Status	2 Maintains value > 92% on room air 1 < 92% - Requires supplemental O_2 0 Saturation < 90% with supplemental O_2 **Pre-op O_2 Sat** _____	2 Maintains value > 94% or room air or equivalent to pre-op status 1 < 92% - Requires supplemental O2 0 Saturation < 92% with supplemental O_2						
Pain Assessment	2 None or mild discomfort 1 Moderate to severe pain controlled with IV analgesics 0 Persistent or severe pain	2 None or mild discomfort, acceptable to patient 1 Pain requiring further intervention 0 Moderate to severe, controlled with IV meds						
Emetic Symptoms	2 None or mild nausea with no active vomiting 1 Transient vomiting or retching 0 Persistent moderate to severe nausea and vomiting	2 None or controlled and acceptable to patient 1 Further treatment required 0 Uncontrolled						
Operative Site Wound	2 N/A / None or minimal drainage or blood loss consistent with surgical procedure 1 Moderate drainage requiring extra padding/dressing/small stable hematoma 0 Severe drainage/increasing hematoma	2 None or minimal drainage or blood loss consistent with surgical procedure 1 Moderate drainage/requiring extra padding/dressing small stable hematoma 0 Severe drainage/increasing hematoma						
		Total:						

A minimum score of 14 with no score <1 in any category is required for a patient to (1) Enter Phase 2 recovery from OR Procedure Room or (2) Transfer from PAR to Nursing unit or Phase 2 recovery. A score of 16/16 is required to discharge patient from phase 2 SSCU to home.

Place Patient Label Here

POST ANESTHESIA RECOVERY RECORD

Postoperative Record

	PAR		DCS
Time	O/A	D/C	D/C
Dressings: N/A			
#1			
#2			
#3			
#4			
Peri-pad			
Drains: N/A			
#1			
#2			
#3			
Catheter N/A			
Urethral/SP			
CBI Solution			
Other N/A			
N/G-aspirate			
Chest Tube-drainage			
Suction-cm H_2O			
Lines N/A			
Epidural			
CVC			
Arterial			
Other			
Immobilizer: N/A			
Pehr Splint			
POP Cast			
Splint/OCL			
Sling			
Other			
Operative limb(s) elevated			
Packs N/A			
Dental			
Vaginal			
Rectal			
Nasal			
Ice			

Warming Blanket N/A TIME ON: _____ TIME OFF: _____

NURSES' NOTES

XRAY:	Time:	Site:	Viewed:
	Time:	Site:	Viewed:
LAB:	Time:		Dr. Aware:
EKG:	Time:		Viewed:

NEUROVASCULAR ASSESSMENT: N/A

	Admission		PAR D/C		DCSS Discharge	
	Lt	Rt	Lt	Rt	Lt	Rt
GAP REFILL						
PULSES:						
Radial						
Dorsalis Pedis						
Posterior Tibial						
COLOR:						
Pink/Flesh						
Pale						
Dusky						
Mottled						
TEMP:						
Warm						
Cool						
Cold						
Hot						
EDEMA:						
Mild						
Moderate						
Severe						
Absent						
SENSATION:						
Radial						
Ulnar						
Median						
Peroneal						
Tibial						
MOVEMENT:						
Radial						
Ulnar						
Median						
Peroneal						
Tibial						

R.N. SIGNATURE

Print Name	Signature	Initials

RECORDING CODE

CAPILLARY REFILL
< = < 3 secs > = > 3 secs

PULSE
0 = absent
1 = weak
+2 = moderate
+3 = strong
+4 = bounding
D = pulse by Doppler

COLOUR/TEMP/EDEMA/CAST
☑ applicable box

SENSATION
P = present
A = absent
N = numbness
T = tingling

MOVEMENT
S = strong
M = moderate
W = weak
A = absent

Place Patient Label Here

POST ANESTHETIC RECOVERY RECORD

Postoperative Record

Initial																							
Time																							
BLOOD PRESSURE & PULSE: SYSTOLIC V; DIASTOLIC ●; RADIAL •; R - regular I - irregular; ART LINE V Red ●; APICAL x																							
230																							
220																							
210																							
200																							
190																							
180																							
170																							
160																							
150																							
140																							
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110																							
100																							
90																							
80																							
70																							
60																							
50																							
40																							
30																							
20																							
10																							
MAP																							
CVP																							
Temp N/A																							
SPO_2																							
Respirations - rate																							
- rhythm																							
- depth																							
- quality																							
Sedation Scale (0-3)																							
Pain Scale /10																							
Position																							
Block Level Motor RT																							
LT																							
Sensory RT																							
LT																							
Doctors Visit																							

Time	Medication	Dose	Route	PAS	Init.

Time	Medication	Dose	Route	PAS	Init.

Place Patient Label Here

POST ANESTHETIC RECOVERY RECORD

Postoperative Record

INTAKE								OUTPUT						
Start Time	Solution	Volume	Site	Initial	Time Absorb	Amount	Initial	Time	Urine	Gastric	Drain(s)			Initial
								Sub Totals						
					Total on Discharge							Total on Discharge		

CARDIAC MONITOR STRIPS/Nurses Notes cont'd

DISCHARGE ASSESSMENT INPATIENT

Discharge Time: To Ward:

Vital Signs: BP: Pulse: Resp: SPO_2 Discharge Score: /16

Pain Assessment: /10 Comments:

Physician's Orders Checked: ☐ Faxed: ☐ N/A ☐ Discharged by: R. N.

Transferred by:

Signature of Receiving Nurse on Ward: R. N. Time:

TO DCSS FROM PAR _____ _____ RN Pain Assessment /10 D/C Score /16

DISCHARGE ASSESSMENT DAYCARE PATIENTS

Discharged at: _____ with _____

Post op instructions: YES ☐ NO ☐

Pain Assessment: /10

Discharge Score /16

PRESCRIPTION: YES ☐ N/A ☐ _____

Medication given: YES ☐ N/A ☐ _____

Physician's Orders Checked ☐

Discharged by: _____ R. N.

Place Patient Label Here

Postoperative Record

SURGICAL DAY CARE RECORD

Procedure:	OR Time:
Diagnosis:	Anesthetist:

DATE: TIME: HT: _____ cm WT: _____ kg

✦ PRE-OP ADMISSION ASSESSMENT ✦	CHECK WHEN ASKED ✓	
Heart/Clotting		
BP		
Lungs/Smoking		
Jaundice		
GI/GU		
Diabetes		
Alcohol		
Meds		
(time last taken)		
LMP		?Pregnancy:
Allergies		**Latex:**
Reactions		
Major Illness		
Skeletal/Joint Problems		
Major Surgery		
Anaesthetic Problems		

Escort: Phone: SIGNATURE: R.N.

TIME	PROGRESS NOTES

Last Solid Food at:

Last Clear Fluids at:

PRE-OP CHECKLIST		YES	NO	N/A
Identification Band				
Consent				
History/Physical				
Hemoglobin				
ECG				
Allergies:	Recorded			
	Armband			
Local Skin Prep				
Vital Signs (see reverse)				
Do Not take BP on:	☐ Lt ☐ Rt ☐ N/A			
No BP arm labelled:	☐ Yes ☐ No ☐ N/A			
Pre-Op Medication				
Voided				
Capped Teeth				
Remove:	Dentures			
	Jewelry/Clothing			
	Make-up/Nail Polish			
	Prosthesis			
Old Chart Present				
Operative Site Marked				
ECG Leads Applied				
Socks/Hat On				
Pre-Op Teaching Done				
Patient able to walk to OR				

Completed by: _____ **R.N.**

Patient Admitted to O.R. by: _____ **R.N.**

Place Patient Label Here

SURGICAL DAY CARE RECORD

Postoperative Record

Day Care Location: ☐ SDC ☐ FFDC

Pre-Op VS's: T_____ P_____ R_____ BP_____ O2Sat_____

☐ Neurovascular Flowsheet Initiated Pre-Op

POST-OPERATIVE NOTES

Type of Anaesthetic: ☐ Gen ☐ Spinal ☐ Epidural ☐ Local ☐ Sedation ☐ Block

POST-OPERATIVE VITAL SIGNS

TIME													
BP V ^ / Pulse 220													
210													
200													
190													
180													
170													
160													
150													
140													
130													
120													
110													
100													
90													
80													
70													
60													
50													
40													
Resp.													
Temp.													
Drsg/Dry													
Sedation Level													
Pain Scale (0-10)													
INITIALS													

Key for Sedation Level: 0 = None 1 = Mild 2 = Moderate 3 = Severe S = Sleeping

PROGRESS NOTES

Ride Coming at: _____

TIME	

INITIALS AND SIGNATURE

DISCHARGE CRITERIA	YES	NO	N/A	COMMENTS
Alert and Orientated				
V.S. Stable and Within Normal Limits				
Dressing/Operative Site Dry				
Able to Ambulate Unassisted				
Tolerating Fluids				
Voided				
Nausea, Vomiting, Dizziness Minimal/Nil				
Patient States Pain is at Acceptable Level				
Prescription Given				
Discharge Instructions Given				
Adult Present to Accompany Patient				

TIME: _____ **MODE:** _____ **SIGNATURE:** _____ **R.N.**

Place Patient Label Here

INTRA-OPERATIVE RECORD

Intraoperative Record

☐ LGH ☐ SGH ☐ SMH ☐ PRGH

Date_____ Room _____ Patient in OR _____ Anes Ready_____ Pt. Exit OR _____ (enter PAR/ICU/CRR/SSCU)

Set-up Start _____ Anes Start _____ Surgery Stop _____ Surgeon in OR _____ Surgery Start _____

SSCL Briefing: ☐ Y ☐ N Timeout: ☐ Y ☐ N Debriefing: ☐ Y ☐ N

Quality Control: L:_____ Q:_____ C: _____

Case # _____ ☐ Emergency ☐ Fast-tracked

Anesthetic Type #_____ ASA# 1 2 3 4 5

Wound Classification ☐ Clean ☐ Clean Contaminated ☐ Contaminated ☐ Dirty

	Time	Signature
Patient Exit PAR		
Patient Enter DCSS		
Patient Exit DCSS		

IV ANTIBIOTIC TRACKING

Pre-op Antibiotic: ☐ N/A

End time_____ Medication _____ Initial _____

Intra-op Antibiotic: ☐ N/A

End time _____ Medication _____ Initial _____

Flash Sterilization: ☐ Y ☐ N Reason _____

ENDOSCOPE ☐ N/A

Type_____ #_____

PROCEDURE(S) _____ ☐ Case Cancelled ☐ Pt. Expired

_____

_____

COUNT STATUS ☐ N/A

☐ Correct - Surgeon Notified

☐ Incorrect - Surgeon Notified

# of Specimens: Pathology _____ Frozen Section _____ Cytology _____ Culture _____

Other _____ ☐ Specimen discarded as per Surgeon's request

Allergies: ☐ NKA ☐ See Allergy form (LGH)

_____

_____

PRECAUTIONS ☐ Airborne ☐ Contact ☐ Droplet ☐ N/A

☐ Latex ☐ MH ☐ Cytotoxic

Other:_____

NAMES (Print)

Surgeon
1. _____
2. _____
3. _____

Anesthesiologist
1. _____
2. _____

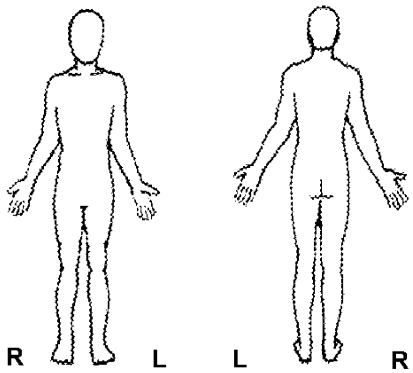
Surgical Assistant
1. _____
2. _____

Anesthetic Assistant
1. _____

1. X-ray _____
2. Vendor _____
3. Other _____

_____

SITES



		A for Anesthesia S for Surgeon **APPLIED (initials)**
BP Cuff	BP	_____
ECG lead/sclips	•	_____
Safety Strap	⌒	_____
ESU pad/plate	X	_____
Site Satisfactory ☐ Yes ☐ No		
Defib/Pacing pads	○	_____
Site Satisfactory ☐ Yes ☐ No		
SPO_2	*	_____
Nerve Stimulator	NS	_____

	NAME (Print)	INITIALS	SIGNATURE	STATUS	TIME IN	TIME OUT
SCRUB					/	/
					/	/
					/	/
					/	/
CIRCULATE					/	/
					/	/
					/	/
					/	/
					/	/

ESU: ☐ N/A

#1_____ cut _____ coag _____

#2_____ cut _____ coag _____

Bipolar #_____ setting _____

Other #_____ setting _____

Smoke evacuator # _____ ☐ N/A

NURSE'S NOTES

_____

_____

_____

PART 1 -WHITE - PATIENT'S CHART PART 2 - CANARY - OPERATING ROOM COPY

INTRA-OPERATIVE RECORD

Intraoperative Record

POSITIONING

☐ Supine ☐ Lithotomy Lateral (side down) ☐ R ☐ L ☐ Prone ☐ Beach Chair

Arms R L
☐☐ Armboard
☐☐ Across Chest
☐☐ At side
Other _____

R L
☐☐ Padded with foam/gel
☐☐ Hand Table

R L
☐☐ Kraus armboard

Head
☐ Pillow
☐ Donut
☐ Horsehoe Donut
Other _____
☐ Mayfield Pins
☐ Gentle Touch Pillow
☐ Mayfield horseshoe
☐ TMAX

POSITIONING AIDS ☐ N/A

☐ Allen Stirrups
☐ Bolsters
☐ Candy Cane
☐ Foam/Gel _____
☐ Fracture Table
☐ Gel Pad
☐ Jackson Frame
☐ Kidney Rest
☐ Kirschner Foot Post
☐ Peg Board
☐ Pillows _____
☐ S Frame Foot Holder
☐ Sandbags _____
☐ Shoulder Roll
☐ Sleds (Arm)
☐ Spider
☐ Stuhlberg
☐ Thigh Post
☐ Tmax
☐ Vac Pac
☐ Wedge _____
☐ Wilson Frame
☐ Yellowfin
☐ Other _____

CALF COMPRESSION DEVICE # _____ ☐ N/A
Applied by _____ Activated by _____ Start Time _____
TED's Size _____ ☐ N/A

HYPO/HYPERTHERMIA UNIT # _____ ☐ N/A
Warming blanket: ☐ Upper ☐ Lower ☐ Full ☐ Under body
Temp setting _____ °C Probe: ☐ Oral ☐ Nasal ☐ N/A

PREP ☐ N/A
Prepped by _____ Clipped by _____
☐ _____ CHG w/ _____%alcohol ☐ CHG Wash
☐ _____ CHG w/ _____%alcohol
☐ Proviodine Iodine
☐ Proviodine Iodine Wash
☐ Tincture Iodine (Surgeon request)
☐ Saline/Water Rinse

TOURNIQUET # _____ ☐ N/A
Cuff size _____ Applied by _____
☐ Rt. Arm Pressure _____ Time on _____ Time Off _____
☐ Rt. Leg Pressure _____ Time on _____ Time Off _____
☐ Lt. Arm Pressure _____ Time on _____ Time Off _____
☐ Lt. Leg Pressure _____ Time on _____ Time Off _____
Surgeon notified: ☐ 1 hr. ☐ 1.5 hr. ☐ 2 hr.
Site satisfactory: ☐ Yes ☐ No

MEDICAL IMAGING ☐ N/A
X-ray C-Arm
Pt. area protected _____

OTHER SURGICAL EQUIPMENT ☐ N/A
Item _____ # _____
Item _____ # _____

INSUFFLATOR# _____ Preset Pressure _____ mmHg Flow Rate _____ / min ☐ N/A

URINARY CATHETER: ☐ IN SITU ☐ N/A
Size _____ Type _____ Balloon with _____ Inserted by _____ Removed by _____

DRAINS: (type & size) (site) (location)
_____ ☐ Sutured ☐ Other _____ _____
_____ ☐ Sutured ☐ Other _____ _____

PACKS ☐ N/A
Type _____ Size _____ Location _____

MEDICATION
_____
_____
_____
_____
_____

IRRIGATING SOLUTIONS **Vol. used**
☐ Cystosol _____ ml
☐ Normal Saline _____ ml
☐ Water _____ ml

Mixed Irrigation Solutions: **Vol. used**
☐ Adrenalin _____ mg in _____ mL Normal Saline _____ ml
☐ Bacitracin _____ units in _____ mL Normal Saline _____ ml

Other _____

CLOSURE TYPES
☐ Staples ☐ Absorbable Suture ☐ Non Absorbable Suture

DRESSINGS
☐ Mepore
☐ Mesorb
☐ Gauze
☐ Abd
☐ Telfa
☐ Jelonet
☐ Cotton Bandage
☐ Tensor
☐ Shoulder Immobilizer
☐ Opsite
☐ Peroad
☐ OCL
☐ POP
☐ POP Splint
☐ Sorfrol
☐ Mastoid
☐ Cottonball
☐ Tubigrip
☐ Jones
☐ PEHR Splint
☐ Steristrips
☐ Mastisol
☐ Mesh Pants
☐ Tape _____
☐ Silastic Nasal Splint
☐ Foam
Other: _____

PROSTHETICS/IMPLANTS PRGH - stickers on back ☐ N/A
☐ LGH - refer to Implant Record

LASER ☐ N/A
☐ LGH - refer to Laser Log

Place Patient Label Here

INTRA-OPERATIVE RECORD

Intraoperative Record

SCHEDULED CASE # - case number from slate

INSTRUCTIONS AND DEFINITIONS OF OR TIMES:

Setup Start - Personnel begin setting up supplies and equipment in OR for next case.
Patient In OR- Arrival time of patient in OR.
Surgeon In OR- Arrival time of Surgeon in OR.
Anes. Start - The time when anesthesia begins preparing the patient for an anesthetic. This includes the time the block is started whether inside the OR or at another location.
Anes. Ready - The time when the patient is ready for positioning, skin prep and draping.
Surgery Start - Surgical incision or insertion scope or commencement of examination.
Surgery Stop - Instrument and sponge counts completed and verified as correct, all post-op x-rays done in OR are complete. All dressings, drains, and casts are completed, physicians have finished all procedure-related activities on the patient.
Patient Exit OR - Patient leaves the OR.

QUALITY CONTROL CODE AND INSTRUCTIONS

Use the following code to record on the front of this form under the appropriate letter L, Q or C the reason that a procedure or case does not go as planned. Multiple explanations can be chosen under any category.

L = LATE
Identifies Staff that may have caused a late start. **Note for lst case of the morning patient in-room time is 0745. Anesthesia induction must be started by 0750. Anytime after that is LATE.**

CODE	EXPLANATION
1	Surgeon
2	Anesthesiologist
3	Patient
4	Housekeeping
5	Anesthesia Assistant
6	Nursing
8	EEG Tech
9	Radiology Tech
10	Perioperative Assistant
11	Escort/Porter
13	Pediatrician
14	Surgical Assist

Q = QUALITY
Identifies reason why procedure took longer than scheduled time or expands on reason why proce- dure start was later than scheduled patient in room time.

CODE	EXPLANATION
1	PAR Full (On Hold)
2	Equipment Breakdown/Unavailable
3	New Case Cart Required
4	X-Ray required
5	Waiting for Lab Results
6	Interpreter Required
7	Pt wishes to speak with Surgeon/Anesthetist
8	Delayed by previous case
9	No Consent and/or unsigned
10	Fire Alarm or Code Alert
11	Blood Products Delay
12	Critical Blood Shortage
13	Redraping/New setup Required
14	Teaching
15	Delayed due to Count Discrepancy
16	Pt not sent for by OR
17	Booking- Error in booking Case
18	Surgical site not signed
19	Doctor- Bumped by Emergency
20	Doctor- Inadequate time
21	Doctor- Late case moved to Emerg Slate
22	Pt- Not ready in PCC/SSCU/Ward
23	Pt has not voided
24	New Case Cart Required/ Pick List Issue
25	Instruments unavailable
26	Waiting for patients old chart
27	Item flashed

C = COMPLEXITY
Identifies Surgeon and/or Anesthesiologist complication dur- ing primary, or return to surgery.

CODE	EXPLANATION
1	Cardiac Arrest
2	Difficult Intubation
3	Difficult Lines
4	Pt slow to wake up
5	Drug Reaction
6	Difficult Regional Anesthetic
7	Special Needs/Disability
8	Pt Admit unplanned
9	Surgical Complications
10	Incorrect/Inadequate Pre-op Prep
11	Unexpected Pathology
12	Vascular Complications
13	Anesthesia Complications
14	Obesity
15	ICU/CSICU Delay
16	Emergency/Trauma
17	Difficult Epidural
18	Difficult Peripheral Lines
19	Difficult Central Lines
20	Difficult Urinary Catheterization
21	Isolation Precautions

ASA # -Patient physical status rating as determined by the Anesthesiologist. 1-5 or 1E-5E

ANESTHETIC TYPE - only one (1) code per case

NUMBER	DESCRIPTION
1	General
2	BLOCK - Spinal
3	BLOCK - Epidural
4	General with Epidural or Spinal
5	BLOCK - Other (includes IV block)
6	Monitored Anaesthesia Care (Anesthesiologist present)
7	LOCAL (no Anesthesiologist present)
9	Other Anaesthetic (includes conscious sedation with no Anesthesiologist present) BLOCK - Epidural and Spinal
10	

Do not place implant labels on this form - use Intraoperative Implant Record.

Place Patient Form Label Here

CONSULTATION REQUISITION (BCC)

Consult Request

- ☐ ELECTIVE - when specialist available
- ☐ URGENT - within 2 working days
- ☐ EMERGENT within 24 hours

CONSULTANT REQUESTED - NAME: _____ MSC No.: _____ FAX: _____

SPECIALITY: _____ PHONE: _____

PATIENT NAME: _____ AGENCY CHART No.: _____

UNIT/WARD: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE: _____

TEMPORARY ADDRESS: _____ PHONE: _____

MEDICAL INSURANCE NUMBER: _____

FAMILY DOCTOR: _____ PHONE: _____

DIAGNOSIS: _____

PROBLEM:

APPOINTMENT BOOKED ☐

FOR DR. OFFICE ☐ ACU SPECIALS ☐

DATE: _____ TIME: _____

PATIENT NOTIFIED ☐

REQUESTED BY: _____

DATE: _____

CONSULTANTS: PLEASE DICTATE YOUR REPORT FOR THE CHART
REFERRAL CARD WILL BE SUBMITTED TO MSP UPON TRANSCRIPTION OR RECEIPT OF A TYPEWRITTEN REPORT

PART 1 - WHITE - CONSULTANT
PART 2 - CANARY - HEALTH RECORDS, TRANSCRIPTION SERVICES with Referral Card Original

Place Patient Label Here

FLOWSHEETS

ECG STRIP FLOWSHEET

Instructions: Attach strip within the black box using clear tape. DO NOT COVER any important information with tape because the adhesive dissolves the ink.

Date: _____ Time: _____ Lead: _____ Atrial Rate: _____ Vent. Rate: _____
Reg: _____ Irreg: _____ PR: _____ QT: _____ QTc: _____ QRS: _____ ST: _____ T: _____
Rhythm: _____
Signature: _____ Printed name: _____

Date: _____ Time: _____ Lead: _____ Atrial Rate: _____ Vent. Rate: _____
Reg: _____ Irreg: _____ PR: _____ QT: _____ QTc: _____ QRS: _____ ST: _____ T: _____
Rhythm: _____
Signature: _____ Printed name: _____

BC CANCER

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Appendix B: BC Cancer Surgical Safety Checklist Guide

BRIEFING: Before Induction of Anesthesia or Administration of Procedural Sedation	**TIME-OUT:** Before Initial Incision or Introduction of Scopes	**DEBRIEFING:** Before Patient is Tranferred Out of the Operating Room
☐ Patient identification ☐ Known allergies ☐ Confirmed consent ☐ Surgical site & site marked/Not applicable ☐ Patient positioning ☐ Equipment/implants/imaging available or not applicable ☐ Antibiotic prophylaxis/Not applicable ☐ Any patient specific concerns or alerts? Signature _____ Printed Name_____ Date/Time_____ ___	☐ All team members introduced themselves by name ☐ Patient name ☐ Known allergies ☐ Procedure and consent ☐ Surgical Site and side/ Not applicable ☐ Antibiotics given/Not applicable ☐ VTE/DVT Prophylaxis ☐ Are there any other concerns/anticipated critical events before proceeding? Signature _____ Printed Name_____ Date/Time_____ ___	☐ Surgical Procedure to be recorded ☐ Counts complete/Not applicable ☐ Speciment number/type documentation complete and correct ☐ Equipment issues to be addressed/Not applicable ☐ Surgeon/proceduralist/anesthesiologist and nurse to review key concerns for recovery and management of patient ☐ If perioperative incident has occurred, any PSLS required/Not applicable? ☐ Any final concerns for patient's recovery? Signature _____ Printed Name_____ Date/Time_____ ___
☐ Nursing ☐ Surgery ☐ Anesthesia ☐ Radiation Therapist	☐ Nursing ☐ Surgery ☐ Anesthesia ☐ Radiation Therapist	☐ Nursing ☐ Surgery ☐ Anesthesia ☐ Radiation Therapist

Place Patient Form Label Here

Transfusion Records

BCC PG BLOOD PRODUCT TRANSFUSION RECORD

PATIENT ABO/RH GROUP: _____

Documentation of a single transfusion of one or more units

Blood Product Number [1]	Blood Product Type	Blood Product ABO/Rh Group	Transfusion Start-Date & Time	Administered By (Initials)	Checked By (Initials)	Transfusion Stop-Date & Time	Mechanical Infusion device [2] or pressure bag (PB) used Yes (identify) / No	Transfusion Reaction Noted [3] Yes/No

1 The Blood Product Number shall be written in ink. Please do not use only the stickers from the blood product bag.
2 Mechanic Infusion Devices documentation key: Rapid Infuser (RI), Fluid Warmer (FW), Syringe Pump (SP), Intravenous Infusion Pump (IVP)
3 All Transfusions Reactions shall be documented on the Transfusion Reaction Report form

Venous Access Device (VAD): type _____ size (gauge/Fr) _____

Blood Product Administration set used: _____ Straight type blood set _____ Y-type blood set _____ Basic administration set with vented adaptor

All patients shall receive recipient's information package: Recipients Notification and Transfusion Reaction Information

Recipient's information package given to: _____ Relationship to patient: _____

BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

Centre for the North

Central Line Catheter: Care and Maintenance Record

Catheter Length: Internal: _____cm (ˆ single ˆ double) **IVAD - needle size:_____**
Insertion Site: _____ **Insertion Date: ___/___/___**

Date: DD/MM/YY Time:	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Assessment	**Peripherally Inserted Central Line (PICC)**						
Intact							
Redness							
Pruritus							
Tenderness/Pain							
Swelling							
Warmth							
Exudate: Present							
Description							
Amount							
C/S obtained (if applic)							
Palpable Venous Cord							
Phlebitis Rating Scale							
Internal Measurement	____cm	____cm	____cm	____cm	____cm	____cm	____cm
Dressing							
3000/Tegad/other							
Cleansing Solution							
Protective Barrier							
20 cc saline flush							
Blood return							
Assessment	**IVAD**						
Site: skin/swelling							
Cleansing Solution							
Saline/Heparin	/	/	/	/	/	/	/
Blood Return							
Needle Size							
DARP							
R.N. Initials							

Skin Reaction: R: Redness P: Pruritus V: Vesicle formation

INS 2011 Phlebitis Scale 0: None **1:** Erythema at access site with or without pain **2:** Pain at access site with erythema or edema **3:** Pain at access site with erythema or edema/Streak formation/Palpable venous cord **4:** Pain at access site with erythema and/or edema/Streak formation/ Palpable venous cord > 1 inch in length/Purulent drainage.

Exudate Amount: Sc: Scant S: Small M: Moderate L: Large

References; CP: See Nursing Care Plan ; see DARP

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REGIONAL BRACHYTHERAPY PRE-PROCEDURE CHECKLIST

DATE	TIME	Language Spoken: English ☐ Yes ☐ No Other: Interpreter Signature:
ALLERGIES ☐ IV CONTRAST ☐ NO KNOWN ALLERGIES SURGICAL / PROCEDURE:		History of Anesthetic Complications: ☐ No ☐ Yes If yes, explain:

	INITIALS		BASELINE VITAL SIGNS						
Identification Band			**BP**	**P**	**R**	**T**	**O2 SAT**	**Blood Glucose**	**WT**
Allergy band on ☐ **N/A**									
Consent signed and witnessed									
Date/Time last food _____			**IV Start Time**				Tobacco Use: ☐ Yes ☐ No Alcohol Consumption: ☐ Yes ☐ No Amt: _____		
Date/Time last drink _____			**Cannula Size**						
Bloodwork Reported / EKG Strip (if ordered prior)			**Type of IV Fluid**						
History and Physical Exam									
Bowel Prep: _____			**Medical Conditions/New or Significant:**						
Last time patient voided: _____									
Loose / Capped Teeth / Dentures / Caps									
Prosthesis ☐ N/A			**List any changes to medications since pre-screening assessment:**						
Makeup / Nail Polish / Hair Pins / Jewelry ☐ N/A									
Personal Clothing									
Glasses / Contacts ☐ N/A			**Medication taken today:**						
Hearing Aide / 2 ☐ N/A									
Pacemaker / ICD ☐ N/A									
Pre Procedure Education complete			**Other Bloodwork/Tests done today:**						
BCCA Chart / Applicable Documents									
Site marked ☐ N/A			**Consent for Blood/Blood Products:** ☐ Yes ☐ No ☐ N/A						

PRE OPS MEDS

TIME	MED/ROUTE	INITIALS	TIME	MED/ROUTE	INITIALS

I have been informed that I should not operate a motor vehicle today. ☐ Yes ☐ Not applicable

Patient Signature:

Name of Escort picking patient up and relationship:

Escort's phone #:

ADDITIONAL NOTES

	TIME	NAME (print)	SIGNATURE	INITIALS	DESIGNATION
Pt Admitted by:					
To OR by:					
Other					

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SURGICAL SAFETY CHECKLIST GUIDE

Before induction of Anesthesia

Anesthesiologist begins SIGN IN:

- ☐ Patient identification
- ☐ Known allergies
- ☐ Confirmed consent
- ☐ Surgical site & site marked/Not applicable
- ☐ Patient positioning
- ☐ Equipment/implants/imaging available or not applicable
- ☐ Antibiotic prophylaxis/Not applicable
- ☐ Anesthetic concerns
- ☐ Any patient specific concerns or alerts?

Signature _____
Printed Name _____
Time _____

☐ Nursing
☐ Surgery
☐ Anesthesia

Before skin incision

Surgeon/proceduralist/designate begins TIME OUT:

- ☐ All team members introduced themselves by name

Confirms:

- ☐ Patient name
- ☐ Known allergies
- ☐ Procedure and consent
- ☐ Surgical site and side/Not applicable
- ☐ Antibiotics given/Not applicable

STOP

- ☐ Are there any other concerns before proceeding?

Signature _____
Printed Name _____
Time _____

☐ Nursing
☐ Surgery
☐ Anesthesia

Before patient leaves operating room

Nurse initiates SIGN OUT:

- ☐ Surgical procedure to be recorded
- ☐ Counts complete/Not applicable
- ☐ Specimen number documentation correct
- ☐ Equipment issues to be addressed/Not applicable
- ☐ Surgeon/proceduralist/anesthesiologist and nurse to review the key concerns for recovery and management of this patient
- ☐ If perioperative incident has occurred, any PSLS required/Not applicable?

Signature _____
Printed Name _____
Time _____

☐ Nursing
☐ Surgery
☐ Anesthesia

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REGIONAL BRACHYTHERAPY INTRA-OPERATIVE RECORD

TIME IN OR	ANES START	OR START	OR FINISH	OUT OF OR	SURGICAL SAFETY CHECKLIST	
					SIGN IN	
					TIME OUT	
☐ ALLERGIES	☐ IV CONTRAST	☐ NO KNOWN			SIGN OUT	

SURGICAL / PROCEDURE

ANESTHETIC TYPE (check)					
☐ General	☐ Spinal	☐ Epidural	☐ IV Sedation	☐ Local	☐ Other: _____

TEAM MEMBERS					
Anesthetist		Nurse Break Relief		Physicist	
Surgeon		Radiation Therapist		Physicist	
Surgeon		Radiation Therapist		Other	
Scrub Nurse		Radiation Therapist		Other	
Circulating Nurse		Physicist		Other	

POSITIONING (check)	EQUIPMENT	CATHETERS	WOUND CLASSIFICATION
☐ Lithotomy	☐ Arm on board ☐ RT ☐ LT	☐ Site	☐ Clean
☐ Supine	☐ Safety strap	☐ Type	☐ Clean Contaiminated
☐ Prone	☐ Body safety strap	☐ Size	☐ Contaminated
☐ Lateral ☐ RT ☐ LT	☐ Pillows	☐ NS Instillation Amount:	☐ Dirty
PREP	☐ Gel Pads: _____	☐ Removed Intact	**X-RAY**
☐ Shave prep ☐ N/A	☐ Breast Board		☐ Fluoroscopy
SOLUTIONS	☐ Stirrups		**RADIOPAQUE DYE**
☐ Chlorhexidine 2% - 4%	☐ Thyroid Collar		Conray 60%
☐ Providine Solution 10%			Omnipaque 65%
☐ Normal Saline	☐ Sequential Compression Device Bilateral legs - Serial #:		
☐ Muko	☐ Warming Blanket		
☐ Lubricant	☐ Upper - Temp: Serial #:		
☐ Vaseline	☐ Lower - Temp: Serial #:		

INFILTRATION / ANESTHETIC AGENTS		GYNE APPARATUS
☐ Sensorcaine 0.5% with Epi ___mls	☐ Lidocaine jelly 2% _____mls	☐ Segmented Cervix: Piece # /s:
☐ Marcaine 0.25% plain ____mls	☐ Lidocaine with Epi 1% ____mls	

SEEDS	#	SEEDS / NEEDLES	#	
☐ Fiducial Markers		☐ I-125		☐ Tandem & Ovoids
☐ Palladium-103		# of Needles		☐ Tandem & Ring
☐ Specimen				☐ CILT or Obturator
☐ Type:				☐ Vaginal Interstitial - Number of Needles
☐ Other:				☐ Vaginal Packing
				☐ Dressing

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REGIONAL BRACHYTHERAPY INTRA-OPERATIVE RECORD

☐ NO COUNT ☐ SKIN COUNT

						Scrub Nurse	Circulating Nurse	Correct Yes	Correct No
Lap Sponges					Original Count by:				
4X4 Raytec					#1 Closure				
4X8 Raytec					#2 Closure				
Sutures						+ / -	+ / -	+ / -	Total ✔
Inj.Needle (2 parts)					Other:				
Syringe (3 parts)					Other:				
Blades:					Other:				
Relief Signature				Initial	Relief Signature				Initial

ADDITIONAL NOTES

		TIME IN	TIME OUT
Scrub Nurse Signature			
Circulating Nurse Signature			
Releif Signature			

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REGIONAL BRACHYTHERAPY PARR CLINICAL RECORD

DATE: **TIME IN:** **TIME OUT:**

Admitted by: _____

Anesthetist: _____

Position on Admission: _____

Procedure: _____

Anesthetic: ☐ General ☐ Local ☐ Regional

Pre-op BP	Allergy / Alert

FIO2	O2 SAT	START	D/C	INITIALS

PAR SCORE TIME										
Muscle Strength	Strong = 2 Weak = 1 Nil = 0									
Able to DB & C Dyspnea Ltd Breath Apnea	= 2 = 1 = 0									
BP + / - baseline BP + / - 20-50 baseline BP + / - 50 baseline	= 2 = 1 = 0									
Fully Awake Arousable Not Responding	= 2 = 1 = 0									
Normal Pale dusky / blotchy etc Cyanotic	= 2 = 1 = 0									
Monitor vitals q 5 mins until score of 7 then q 15 until score of 9 then q 1 h	**Totals**									
	Initials									

TIME																						
TEMP 220																						
200																						
180																						
160																						
140																						
120																						
100																						
80																						
60																						
40																						
RESP PAIN 0-10																						

DRESSINGS ON ADMISSION

DISCHARGE

TIME	MEDICATION	REASON	RESPONSE	INITIALS

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REGIONAL BRACHYTHERAPY PARR CLINICAL RECORD
DATE: TIME IN: TIME OUT:
Admitted by:
Anesthetist:
Position on Admission:
Procedure:
Anesthetic: ☐ General ☐ Local ☐ Regional
Pre-op BP
Allergy / Alert
FIO2 O2 SAT START D/C INITIALS
PAR SCORE TIME
Muscle Strength Strong = 2 Weak = 1 Nil = 0
Able to DB & C = 2 Dyspnea Ltd Breath = 1 Apnea = 0
BP + / - baseline = 2 BP + / - 20-50 baseline = 1 BP + / - 50 baseline = 0
Fully Awake = 2 Arousable = 1 Not Responding = 0
Normal = 2 Pale dusky / blotchy etc = 1 Cyanotic = 0
Monitor vitals q 5 mins until score of 7 then q 15 until score of 9 then q 1 h
Totals
Initials
TIME TEMP 220 200 180 160 140 120 100 80 60 40 RESP PAIN 0-10
DRESSINGS ON ADMISSION
DISCHARGE
TIME MEDICATION REASON RESPONSE INITIALS
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REGIONAL BRACHYTHERAPY PARR CLINICAL RECORD

TIME	INTAKE				TIME	OUTPUT		INITIALS
START	SOLUTION	PO/IV	AMOUNT	STOP		URINE		

TIME	NURSES NOTES

ECG STRIP

DISCHARGE TIME: **ESCORT:**

MODE:

Prescription given: ☐ Yes ☐ No **Post-Op Teaching and written instructions given:** ☐ Yes ☐ No

☐ Full set of vitals done prior to discharge

Comments:

RN SIGNATURE:	RN SIGNATURE:

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REGIONAL BRACHYTHERAPY PARR CLINICAL RECORD
TIME | INTAKE | TIME | OUTPUT | INITIALS
START | SOLUTION | PO/IV | AMOUNT | STOP | URINE
TIME | NURSES NOTES
ECG STRIP
DISCHARGE TIME: ESCORT:
MODE:
Prescription given: ☐ Yes ☐ No Post-Op Teaching and written instructions given: ☐ Yes ☐ No
☐ Full set of vitals done prior to discharge
Comments:
RN SIGNATURE: RN SIGNATURE:
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JUNE.2018

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INTRA-OPERATIVE RECORD

☐ BC Cancer

OR # _____ **Case#** _____ Ward: _____ Enter ECC/PreOP _____

Quality Control Q: _____ A: _____ C: _____

Date: _____

Block Room _____	Anes Start _____	Surgery Stop _____
Set-up Start _____	Anes Ready _____	**Debriefing** ☐ **Y** ☐ **N**
Pt ENTER OR _____	**Time out** ☐ **Y** ☐ **N**	Pt Exit OR _____
Briefing ☐ **Y** ☐ **N**	Surgery Start _____	

Clean up Start: _____ Clean up End: _____

Anesthetic Code # _____ ASA# _____

ANESTHESIA TEE # _____ Anesth Scope # _____

Surgical site marked ☐ Yes ☐ No ☐ N/A

Preop Antibiotic END time: _____ ☐ No ☐ N/A

Discharge to _____ ECC/PACU Exit _____ **Wound Classification:** ☐ Clean ☐ Clean/Contam ☐ Contam ☐ Dirty/Infected

PROCEDURE(S): _____ **Procedure Scope #:** _____

_____ ☐ No count required

_____ ☐ Case cancelled ☐ Pt. expired

# of Specimens Sent: Pathology_____ Rush_____ Research_____ Micro_____ Misc._____

☐ Allergies ☐ NKA ☐ See Allergies Sheet

☐ ALERTS

☐ Latex Protocol ☐ BP Protocol ☐ Left ☐ Right

Items Flashed: ☐ Yes

Details: _____

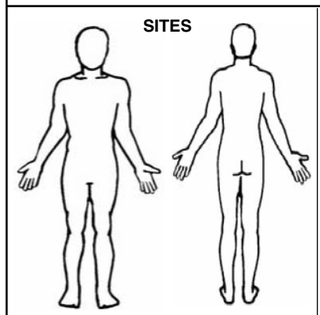
NAMES: (Print)

Surgeon	Anesthesiologist
1.	1.
2.	2.
3.	3.
Surgical Assistant	**Anesthetic Assistant**
1.	1.
2.	2.
3.	3.

1. AT: _____
2. PA: _____
3. Perfusion: _____
4. X-ray: _____
5. EEG: _____
6. Vendor: _____
7. Other: _____

	NAME (PRINT) FIRST + LAST INITIAL	ID#	INITIALS	STATUS	TIME IN	TIME OUT	TIME IN	TIME OUT
SCRUB								
CIRCULATE								

SITES



Supine Prone

A for Anesthesia / S for Surgeon/ P for PREOP		APPLIED (Initials)	REMOVED (Initials)	LEFT ON	SITE SATISFACTORY YES	SITE SATISFACTORY NO
megadyne (Yes) ☐						
ESU pad/plate	X				☐	☐
ECG leads/clips	•			☐	☐	☐
Defib/Pacing pads	O			☐	☐	☐
Safety Strap	⌒				☐	☐
Eye Pads	E				☐	☐
Cotton Balls	C					
Throat Pack	T					
BP Cuff	BP			☐	☐	☐

ESU:

#1 _____ cut _____ coag _____

#2 _____ cut _____ coag _____

#3 _____ cut _____ coag _____

Bipolar # _____ setting _____

Other # _____ setting _____

PREP SOLUTIONS:

Providone-Iodine: ☐ 5% ☐ 10%

CHG: ☐ .05% ☐ 2% ☐ 4%

☐ aqueous ☐ alcohol ☐ tinted ☐ untinted

Prep completed by: _____

Hair clipped by: _____

Positioning

☐ Supine ☐ Lithotomy Lateral (side down) ☐ R ☐ L ☐ Prone ☐ Sitting Beach Chair

Arms

R	L		R	L		R	L	
☐	☐	Armboard	☐	☐	Padded with foam/gel	☐	☐	At side
☐	☐	Across chest	☐	☐	Boyes Table	☐	☐	Overhead armboard
☐	☐	Toboggan	☐	☐	L-shaped Arm Holder	☐	☐	Arthrex Limb Positioner
☐	☐	Elbow Positioner						

Head

☐ Mayfield ☐ Chan Headrest ☐ Horseshoe ☐ SHEA

☐ Mayfield Pins ☐ Sugita Pins ☐ Head Vac Pac ☐ Pillow

☐ GEL ☐ Gardner Wells Tongs ☐ Beachchair Head Rest

☐ FOAM

Positioning Aids

☐ Allen Stirrups	☐ Candy Cane	☐ Yellowfin	☐ Sandbags	☐ Stullberg	☐ Post
☐ Vacpac	☐ Pillows	☐ Bolsters	☐ Hall-Rang	☐ Jackson Frame	☐ Stryker frame
☐ Wilson frame	☐ Fracture table	☐ Lapidus mattress	☐ S frame foot holder	☐ Gel Pad	☐ Spider
☐ Foam/Gel	☐ Arthrobot	☐ Slocum Knee Holder	☐ Shoulder Roll	☐ Kidney Rest	☐ Blanketrol/TOWEL
☐ Alvarado	☐ Mayo stand	☐ Unitrac	☐ Wedge		

Other _____

_____ **Nurses Initials** _____

VTE Prophalaxis: ☐ Calf Compressor Unit #: _____

Applied by _____ **Activated by:** _____ **Time:** _____

Hypo/hyperthermia unit# _____

☐ flannel by Dr _____

Warm touch blanket ☐ Upper ☐ Lower ☐ Full

TOURNIQUET CONTROL NUMBER _____

ARM ☐ Rt. ☐ Lt. LEG ☐ Rt. ☐ Lt.

APPLIED BY (Signature): _____

PRESSURE _____ mm Hg Total Time_____mins

	Initials & Time			
INFLATE				☐ NOT INFLATED
DEFLATE				

SURGEON NOTIFIED: ☐ 1 Hr ☐ 1.5 Hr ☐ 2 Hr

SITE SATISFACTORY: ☐ Yes ☐ No

TOURNIQUET CONTROL NUMBER _____

ARM ☐ Rt. ☐ Lt. LEG ☐ Rt. ☐ Lt.

APPLIED BY (Signature): _____

PRESSURE _____ mm Hg Total Time_____mins

	Initials & Time			
INFLATE				☐ NOT INFLATED
DEFLATE				

SURGEON NOTIFIED: ☐ 1 Hr ☐ 1.5 Hr ☐ 2 Hr

SITE SATISFACTORY: ☐ Yes ☐ No

Urinary Catheter: ☐ IN SITU In/Out Catheter By _____

Size	Type	Balloon with	Inserted by	Time	Removed at
		H_2O			
		H_2O			

Drains: (type & size) (site) (location)

_____ ☐ stab ☐ incision ☐ sutured _____

_____ ☐ stab ☐ incision ☐ sutured _____

_____ ☐ stab ☐ incision ☐ sutured _____

_____ ☐ stab ☐ incision ☐ sutured _____

ARTICLES INSERTED: _____ ☐ See implant record

ARTICLES REMOVED IN THE OR: _____

IRRIGATING SOLUTIONS: ☐ Mannitol Sorbitol ☐ Plasmalyte ☐ Normal Saline ☐ Water ☐ Ringers Lactate

Drug Added:			☐ Normal Saline	☐ Water	☐ Ringers Lactate	☐ Plasmalyte
☐ Adrenalin	_____mg	in	_____ml	_____ml	_____ml	_____ml
☐ Ancef	_____gm	in	_____ml	_____ml	_____ml	_____ml
☐ Bacitracin	_____units	in	_____ml	_____ml	_____ml	_____ml
☐ Clindamycin	_____mg	in	_____ml	_____ml	_____ml	_____ml
☐ Garamycin	_____mg	in	_____ml	_____ml	_____ml	_____ml
☐ Heparin	_____units	in	_____ml	_____ml	_____ml	_____ml
☐ Methylene Blue	_____mg	in	_____ml	_____ml	_____ml	_____ml
☐ Neosporin	_____ml	in	_____ml	_____ml	_____ml	_____ml
☐ Papaverine	_____ml	in	_____ml	_____ml	_____ml	_____ml
☐ Proviodine	_____ml	in	_____ml	_____ml	_____ml	_____ml
☐ Rifampin	_____mg	in	_____ml	_____ml	_____ml	_____ml

Other

For UBCH Only ☐ Placed on bed

☐ Dentures ☐ Glasses ☐ Belongings ☐ Placed under stretcher Initials _____

NURSE'S NOTES: _____

SOLUTIONS AND DRUGS USED INTRA OPERATIVELY BY SURGEON/RESIDENT

THIS EXCLUDES DRUGS GIVEN BY ANESTHESIOLOGIST

INFILTRATION/ANESTHESIA AGENTS	Time	INITIALS
Adrenaline 1:1000 x cc's (in 1000cc NaCl)		
Cocaine % x cc's		
Marcaine % x cc's		
Marcaine % c Epi x cc's		
Oxytocin 10 units+		
Pitressin units x cc saline		
Ropivacaine 0.5% cc's		
Xylocaine % x cc's		
Xylocaine % preservative free x cc's		
Xylocaine % c Epi x cc's		
Xylocaine jelly 2%		
RADIO OPAQUE DYES		
Conray ☐ 30% ☐ 60%		
Omnipaque		
Optiray		
RADIAL ARTERY SOLUTION		
Ringers Lactate 300ml		
Verapamil 5mg		
Sodium Bicarbonate 0.2 meq		
Heparin 1,000 IU		
Nitroglycerine 2.5 mg		
TUMESCENT FLUID		
Ringers Lactate ml		
Xylocaine % ml		
Adrenaline mg		
OINTMENTS		
Atropine		
☐ Bacitracin ☐ Polysporin (Polytopic)		
☐ Neosporin ☐ Corticosporin		
Betamethasone		
Dexamethasone		
Gentamycin		
Mupirocin		
Tobramycin 0.3		
OPHTHALMOLOGY		
Carbachol		
Ciprodex		
Miochol		
Ocucel (Cellugel)		
Viscoelastic		
☐ IC Green ☐ Vision Blue		
Solucortisone (Solucortef)		
Triamicinolone (Kenalog)		
C3F8 gas _____% _____cc syringe		
SF6 gas _____% _____cc syringe		
OPHTHALMOLOGY DROPS		
Atropine Sulphate		
Brimonidine ☐ 0.5% ☐ 0.2%		
Chloramphenical		
Cyclopentolate HCL 1.0%		
Fluorescein Sodium %		
Gentamycin 0.3%		
Iopidine 0.5%		
Ocuflox 0.3%		
Phenylephrine HCL ☐ 10% ☐ 2.5%		
Pilocarpine ☐ 1% ☐ 2% ☐ 4%		
Tetracaine 0.5%		
Voltaren		
OPHTHALMOLOGY INJECTION		
Ancef		
Dexamethasone 0.5cc		
OPHTHALMOLOGY SURGEON LOCAL BLOCK		
Xylocaine ☐ 1% ☐ 2% cc's		
Marcaine 0.75% cc's		
OPHTHALMOLOGY IRRIGATION SOLUTION		
☐Balanced Salt Solution ☐ BSS Plus 1		
D50%W		
Adrenalin 1:1000		
Dexamethasone		
Vancomycin		

MISCELLANEOUS	Time	INITIALS
Acetic Acid 5%		
Acetone		
Acriflavin		
Anti-Fog		
Avitene		
Bio Glue		
Bone Wax		
Dehydrated Alcohol		
DMSO		
Epinepherine 1:1000 Topical		
Estrogen Cream		
Flagystatin Cream		
Flamazine		
Floseal		
☐ Friars Balsam ☐ Mastisol ☐ Tincture Benzoin co.		
Hydrogen Peroxide 3%		
☐ Jelonet ☐ Sofratulle ☐ Vaseline Gauze		
Lugols Solution		
Medical Adhesive ☐ Holister ☐ Sterispray		
Methylene Blue 10mg / ml		
Mineral Oil		
Muko/Lubricant		
Mitomycin		
Neosynephrine 0.2%		
Nitroglycerine		
Papavarine mg		
Oral Rinse		
Silver Nitrate 1% ☐ solution ☐ applicators		
☐ Surgicel ☐ Surgifoam		
Talc		
Tisseel		
Triamicinolone (Kenalog)		
Visquipaste		
Xeroform		
ANTIBIOTICS		
Tobramycin _____per pkg cement / _____ pkg		
Vancomycin _____ per pkg cement / _____ pkg		
Vancomycin paste _____ gm		
ANTIBIOTIC MIXTURE		
Ancef 1 gm		
Gentamycin 80 mg		
Bacitracin 50,000 u		
Normal Saline 500 ml		
LOCAL ANESTHETIC MIXTURE		
Marcaine % ☐ epi ml		
Xylocaine % ☐ epi ml		
Sodium Bicarbonate % ml		
ORTHO LOCAL MIXTURE		
Ropivacaine		
Fentanyl 100 mcg		
Ketoralac		
OTHER		

BC CANCER
Provincial Health Services Authority

INTRA-OPERATIVE RECORD

☐ BC Cancer

OR # _____ **Case#** _____ Ward: _____ Enter ECC/PreOP _____

Quality Control Q: _____ A: _____ C: _____

Date: _____

Block Room _____	Anes Start _____	Surgery Stop _____
Set-up Start _____	Anes Ready _____	**Debriefing** ☐ **Y** ☐ **N**
Pt ENTER OR _____	**Time out** ☐ **Y** ☐ **N**	Pt Exit OR _____
Briefing ☐ **Y** ☐ **N**	Surgery Start _____	

Clean up Start: _____ Clean up End: _____

Anesthetic Code # _____ ASA# _____

ANESTHESIA TEE # _____ Anesth Scope # _____

Surgical site marked ☐ Yes ☐ No ☐ N/A

Preop Antibiotic END time: _____ ☐ No ☐ N/A

Discharge to _____ ECC/PACU Exit _____ **Wound Classification:** ☐ Clean ☐ Clean/Contam ☐ Contam ☐ Dirty/Infected

PROCEDURE(S): _____ **Procedure Scope #:** _____

_____ ☐ No count required

_____ ☐ Case cancelled ☐ Pt. expired

_____

# of Specimens Sent: Pathology_____ Rush_____ Research_____ Micro_____ Misc._____

☐ Allergies ☐ NKA ☐ See Allergies Sheet

_____

☐ ALERTS

_____

☐ Latex Protocol ☐ BP Protocol ☐ Left ☐ Right

Items Flashed: ☐ Yes

Details: _____

_____

_____

_____

NAMES: (Print)

Surgeon
1. _____
2. _____
3. _____

Anesthesiologist
1. _____
2. _____
3. _____

Surgical Assistant
1. _____
2. _____
3. _____

Anesthetic Assistant
1. _____
2. _____
3. _____

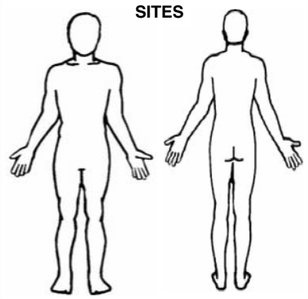
1. AT: _____
2. PA: _____
3. Perfusion: _____
4. X-ray: _____
5. EEG: _____
6. Vendor: _____
7. Other: _____

_____

_____

S	NAME (PRINT) FIRST + LAST INITIAL	ID#	INITIALS	STATUS	TIME IN	TIME OUT	TIME IN	TIME OUT
SCRUB								
CIRCULATE								

SITES



Supine Prone

A for Anesthesia / S for Surgeon/ P for PREOP

		APPLIED (Initials)	REMOVED (Initials)	LEFT ON	SITE SATISFACTORY YES	SITE SATISFACTORY NO
megadyne (Yes) ☐						
ESU pad/plate	X				☐	☐
ECG leads/clips	•			☐	☐	☐
Defib/Pacing pads	O			☐	☐	☐
Safety Strap	⌒				☐	☐
Eye Pads	E				☐	☐
Cotton Balls	C					
Throat Pack	T					
BP Cuff	BP			☐	☐	☐

ESU:

#1 _____ cut _____ coag _____

#2 _____ cut _____ coag _____

#3 _____ cut _____ coag _____

Bipolar # _____ setting _____

Other # _____ setting _____

PREP SOLUTIONS:

Providone-Iodine: ☐ 5% ☐ 10%

CHG: ☐ .05% ☐ 2% ☐ 4%

☐ aqueous ☐ alcohol ☐ tinted ☐ untinted

Prep completed by: _____

Hair clipped by: _____

Scheduled Case # - case number from slate
WARD - final destination for the patient listed on the slate or emergency book slip

Quality Control Code and Instructions

Use the following code to record on the front of this form under the appropriate letter A, Q or C the reason that a procedure or case does not go as planned. Multiple explanations can be chosen under any category.

Q = Quality: Resource Issues

Code	Explanation
1	PAR Full-on hold
2	Equipment breakdown/unavailable
3	New Case Cart Required
4	X-Ray required
5	Waiting for Lab Results
6	Interpreter Required
7	Pt wishes to speak with surgeon/anesth.
8	Delayed by previous/earlier case
9	No Consent and/or unsigned
10	Fire Alarm or Code Alert
11	Blood Products Delay
12	Critical Blood Shortage
13	Redraping/New setup Required
14	Teaching
15	Delayed due to Count Discrepancy
16	Pt not sent for by OR
18	Surgical site not signed / or marked for procedure
22	Pt- Not ready in PCC/ Ward
23	Patient had not voided
24	Case cart/picklist issue
25	Instrument breakdown/unavailable
26	Waiting for patients old chart
27	Item flashed
31	Case order changed

A = Availability of People Involved

Code	Explanation
1	Surgeon
2	Anesthesiologist
3	Patient (anxious/late arrival to pre op)
4	Housekeeping
5	Anesthetic Technician
6	Nursing
7	Perfusion
8	EEG Tech
9	Radiology Tech
10	Perioperative Assistant
11	Escort/Porter

C= Complications

Code	Explanation
1	Cardiac Arrest
2	Difficult Intubation
4	Pt slow to wake up
5	Drug Reaction
6	Difficult Regional Anesthetic
7	Special Needs/Disability
8	Pt Admit unplanned
9	Surgical Complications
10	Incorrect/Inadequate Pre-op Prep
11	Unexpected Pathology
14	Obesity
15	ICU/CSICU Delay
16	Emergency/Trauma
17	Difficult Epidural
18	Difficult Peripheral Lines
19	Difficult Central Lines
20	Difficult Urinary Catheterization
21	Isolation Precautions
22	Post op lines anesthesia
23	Post op block anesthesia

DEFINITIONS:

Enter Preop	Arrival time of patient in PCC / ECC / preOp
Block Room	The time anesthesia enters the block room.
Set-up Start	The time the nurse enters the room to begin setting up.
Patient enter OR	The time the patient enters the operating room.
Anesth Start	The time when anesthesia begins preparing the patient for an anesthetic.
	This includes the time the block is started whether inside the OR or at another location.
Anesth Ready	The time when the patient is ready for positioning, skin prep and draping.
Surgery Start	The time the surgical procedure begins (ie: incision or scope insertion).
Surgery Stop	Time when surgeon related activities have been completed (i.e. dressing, cast, radiology).
Pt Exit OR	Time patient leaves the OR
Clean up Start	Time cleaning staff commences clean up of OR suite
Clean up End	Time cleaning staff completes clean up of OR suite

WOUND CLASSIFICATIONS: note at end of case as events during case may effect classification

Clean	Uninfected wound, no inflammation, closed, and if necessary, w/ closed drainage. Non-penetrating trauma
Clean / Contaminated	Respiratory, alimentary, genital or urinary tract ENTERING ORGANS w/o major break in technique
Contaimated	Open, acute wounds, breaks in technique or gross (visible) spillage, necrotic w/o darinage Key words: ACUTE WOUND AND INFLAMMATION, NONPURULENT
Dirty / Infected	Old traumatic wound w/ retained devitalized tissue and existing infection wound. Wet gangrene Key words: PERFORATED, ABSCESS, RUPTURE, INFECTED, PURULENT, SUPPURATIVE

ASA # - Patient physical status rating as determined by the Anesthesiologist. 1-5 or 1E-5E (E = emergency)

Anesthetic Type - only one (1) code per case

Number	Description
1.	General
2.	Spinal
3.	Epidural
4. GEN/NAB	Combined general and neuraxial - epidural or spinal
5. OTH N/B	Other nerve blocks including intravenous regional anesthesia/Peri bulbular/Retrobulbar
6. MAC	Monitored anesthesia care - monitoring by an anesthesiologist with or without anesthesiologist giving sedation or analgesia; with or without local anesthesia / includes topical
7. LOC/NA	Local anesthesia - no anesthesiologist present / includes topical
8. NLOC/NA	Local no anesthetic
9. OTHER	Other anesthetic - NOT monitored by an anesthesiologist/includes intravenous sedation, nitrous oxide / Nitronox

Preop Ab: time the preop antibiotic was absorbed

****Last page of document****

First Issued:	19-JUNE-2021		
Approving Body:	CST Sustainment Council		
Final Sign Off:	**Name**	**Title**	**Date Signed**
	Steven Brown Andrea Acosta	Director – Clinical Informatics Director – Professional Practice Oncology	15-JAN-2023
Developed By:	**Name**	**Dept.**	**HO**
	Aneil Dhaliwal- Project Manager, Technical Devices	BCC CST	PHSA- BC Cancer
	Provincial Downtime Forms Working Group		
Owner(s):	Steven Brown– Clinical Informatics	Clinical Informatics	
Posted Date:	15-JAN-2024		
Version:	2.1		
Revision:	**Name of Reviser**	**Description**	**Date**
	Andrea Acosta	Revised to reflect provincial downtime forms inventory. Addition of forms for BCC Abbotsford go live: **Abbotsford Regional:** • Brachytherapy Pre-Procedure Checklist • Brachytherapy PARR Clinical Record • Intraoperative Record	08-JAN-2024
	Provincial Downtime Forms Working Group		01-OCT-2023

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